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Willows Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Willows is nursing home that has been converted from a large three storey house close the centre of Birkdale, near Southport. All rooms are for one person and seven rooms have an ensuite toilet and wash basin. The home can accommodate up to 28 people with a variety of nursing needs.
This inspection was carried out over two days on 12-13 April 2017 and was unannounced.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found some anomalies with the way some medicines were being recorded and monitored. This meant there was a risk these medicines were not being administered consistently. We found the checking and auditing systems of medicines needed improving to ensure all anomalies were being identified.

You can see what action we told the provider to take at the back of the full version of this report.

Staff said they were supported through induction, appraisal and the home's training programme. We identified some areas that needed further development and found that some of these had also been identified by the managers previously such as the full introduction of the Care Certificate.
We made a recommendation regarding this.

People we spoke with said they were happy living at the Willows. Staff mostly interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people. We did make some observations that staff did not always communicate appropriately and offer reassurance when carrying out care tasks; this was fed back to the registered manager as an issue for further staff development.
We made a recommendation regarding this.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

The registered manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found some supporting management systems continued to be developed such as, consistency around staff induction and key areas such as, medicines management needed improving.

We found the home supported people to provide effective outcomes for their health and wellbeing. We saw there was effective referral and liaison with health care professionals when needed to support people.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with

vulnerable people. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people.
We found there were sufficient staff on duty to meet people's care needs.
Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training in-house. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety checks were completed on a regular basis so hazards could be identified. Planned development / maintenance was assessed and planned well so that people were living in a comfortable and safe environment.

The home was clean and we there were systems in place to manage the control of infection.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

When necessary, referrals had been made to support people on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the registered manager of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice. Lunch time was seen to be a relaxed and sociable occasion.

People we spoke with and their relatives felt staff had the skills and approach needed to ensure people were receiving the right care.

People felt involved in their care and there was evidence in the care files to show how people had been included in key decisions.

Social activities were organised in the home. People told us they could take part in social events which were held.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw there were records of complaints made and the registered manager had provided a response to these.

The registered manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found some anomalies with the recording of some medicines which meant it was not clear if the medicines had been given as prescribed.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards were routinely monitored.

The home was clean and we there were systems in place to manage the control of infection.

Is the service effective?

Requires Improvement

The service was not wholly effective.

Staff told us they were supported through induction, appraisal and the home's training programme. At the time of the inspection the induction programme did not include the Care Certificate.

We found the service supported people to provide effective outcomes for their health and wellbeing.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.
We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not display reassuring and effective communication when interacting with people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Good

The service was responsive.

Care plans were being reviewed and monitoring of people's care evidenced an individual approach to care.

There were social activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Requires Improvement

The service was not wholly well led.

The registered manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found some supporting management systems continued to be developed and key areas, such as medicines management, needed some improvement. The audits had not picked up on the shortfalls we identified at the inspection.

There was a registered manager in post who provided an effective lead for the home and who had developed a positive culture of care in the home.

Willows Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection which took place over two days on 12-13 April 2017. The inspection team consisted of two adult social care inspectors and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we collated information we had about the service and contacted the social service contracting team to get their opinions. We also reviewed other information we held about the service.

During the visit we were able to meet and speak with 11 of the people who were staying at the home. We spoke with four visiting family members. We spoke with 14 of the staff working at The Willows including care/support staff and senior managers as well as training managers and the provider [owner].

We looked at the care records for five of the people staying at the home including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed at the service. We found some anomalies with the recording of some medicines which meant it was not clear if the medicines had been given as prescribed.

We checked how external preparations [creams] were administered. We found creams for four people had been supplied. We were told these were administered daily by care staff and we saw these were on the Medication administration record (MAR). We asked whether the creams had been applied and we were told they had been applied that day. The administration records were kept in people's bedrooms for care staff to sign when they had applied / administered the cream; we found these had not been completed. For example, one had last been completed the day prior to our inspection and contained gaps in recording over three days, two days and a further two days in March 2017; another chart had numerous gaps in recording of the person's cream totalling 18 gaps in recording over the previous month. The registered manager assured us the creams would have been applied but we were concerned about the lack of accurate records to evidence this.

Some of the people living at the home where prescribed 'thickening' powder to thicken their drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. The thickening powder is a prescribed medicine which needs to be stored safely. We found two examples of thickeners being left accessible in people's rooms. In one example the tin had been left open with the cover removed. This was reported to the registered manager.

For one person we saw the number of scoops of thickening agent needed for Stage 1 was not recorded on their fluid chart though talking with staff confirmed their knowledge of how many scoops to add in accordance with the dietician's instructions. The deputy manager confirmed this information would be added to their fluid chart.

We asked what auditing mechanisms were in place to check if medication was being administered safely. The audit that had been conducted immediately prior to our inspection and did not identify any concern regarding the administration records for the application of external preparations [creams]; we noted, however, the audit tool did not contain reference to the checking of creams or of thickening agents. We questioned the effectiveness of this as the anomalies we saw had not been identified.

Following the inspection the register manager sent us an update telling us immediate action had been taken to ensure thickening agents were stored securely and records had been updated to ensure better information was recorded about the use of thickening agents. Also the audit tools used had been improved to ensure both creams and thickening agents were routinely audited.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures

their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded. This meant the medicines stored in this fridge were safe to use. Medicines were administered from two medicine trolleys. These were securely locked when not in use. We observed part of a medicine round and the staff member administered medicines safely to people.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation.

People at the home had their medicines administered by the staff. People had a plan of care which set out people's care needs and also medicines to be given. The information recorded around medicines helped to support staff to safely administer medicines.

Quantities of medicines received into the home must be checked to provide an accurate stock check. We found quantities of medicines received had been checked and recorded. We reviewed a selection of medication administration records (MARs) and staff had signed to say they had administered the medicines. This helped to ensure medicines were given safely as prescribed.
The MARs contained the contact details for the person's GP and any known allergy and photograph for identification purposes.

A number of medicines were prescribed as 'when required' (PRN). A record was kept of PRN medicines and staff were following protocols for PRN medicines. For example, when to give a PRN medicine and the duration.

Nutritional supplements were given as prescribed for people who had a poor intake.

We spoke with people about whether they felt safe living at the home. People said they felt safe and were not afraid of anything or anyone. Some comments included, "Oh yes [feels safe]. Nothing frightens me here", "Of course; the staff make sure everything's as it's supposed to be and that includes safety, I suppose – doors are locked where necessary, that sort of thing", "Oh yes; the carers help me with my Zimmer [walking frame] because I'm a bit nervous of falling." A relative commented, "Oh yes [person] is safe. [Person] knows they're not at home but they're happy enough and not getting agitated so we know things are okay."

Several people described the way in which they used walking frames and wheelchairs to get about, often with staff support, and how these enabled them to do so safely. The lounge/dining areas were spacious enough to allow people to move unhindered, with or without support.

We saw one person being transferred from chair to wheelchair using a hoist. This was done carefully and safely, with carers taking time to check and readjust the person's position as necessary. There was limited communication between the carers and the person during this transfer but staff took some time to notice that the person needed to have their dignity protected by use of a blanket; the person seemed at ease and comfortable throughout.

Some grab rails were available in bathrooms, and lifting/support equipment was evident in bathrooms. There was fire equipment in all areas and we saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home. This helps to ensure effective evacuation in case of an emergency.

We found arrangements were in place for checking the environment to ensure it was safe. For example,

health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We reported one possible hazard during our inspection and this was immediately rectified. The maintenance person showed us comprehensive records of all of the routine environmental checks made in the home.

All maintenance / safety certificates were up to date we saw that the maintenance person was aware of when these needed updating. Overall there was good attention to ensuring safety in the home and ongoing maintenance.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two staff files of staff recently employed and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

We asked people if they thought there were enough staff on duty at all times to support everyone appropriately. Everybody asked these questions said they were satisfied with staffing levels and didn't feel they normally had to wait very long for support. Comments made included, "Oh yes there's enough staff around", "I think there's enough staff]. I've got a call bell if I need them", "Yes, I'd say so. The attention's good; they advertise twenty four hour care and it certainly is" and "I would say so [enough staff]; there's always somebody about."

During the visit we made observations in the day area/lounge. We saw staff seemed low in numbers in the shared spaces downstairs until late morning. People were seated in the lounge and conservatory without stimulation or anyone to talk to. The TV was on in the lounge and a radio/CD player in the conservatory but nobody appeared to be watching or listening to either. One person asked three times for support in going to the toilet, speaking directly to a different staff member passing by on each occasion. On the third occasion, when they said that they had asked several times, they received support; this was over a period of 30 minutes. The delay may have been due to the fact the person required a hoist. Generally however people did receive support when they needed it.

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was stable. One staff told us, "We all get on well and there's enough staff. The [registered] manager is really good and supports us well."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available. There had been no reports of safeguarding concerns since the past inspection.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails.

When we looked round the home we found it to be clean. There were no unpleasant odours. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when

providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. All of the people living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state. Several people commented that their rooms were cleaned every day and all said they were confident that staff followed hygienic practices.

Requires Improvement

Is the service effective?

Our findings

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. One person told us, "They all know what they're doing; I have no complaints at all." Relatives we spoke with commented, "Yes, and one of them [staff is great at coaxing [person] to leave their room and go downstairs. They're the only one [carer] who can do that; nice person" and "The nursing staff are getting to know [person's] medication and equipment. The manager says they've all had [medication specific] training but they're having refreshers on the job to make sure."

We were told the provider had set up an academy with training managers to oversee the training requirements for staff employed at the Dovehaven homes. The Dovehaven academy set out short term and long term objectives for the staff in respect of assessing staff's training needs for subjects they consider mandatory and staff were enrolled on formal qualifications in care. This is to ensure the staff have the skills, knowledge and expertise to meet people's individual needs and to further their learning and development.

We looked at the induction process for new staff employed at the home. The registered manager explained the induction process which included a standard checklist of information carried out over the first few days of employment, a handbook for new staff, some shadowing of experienced staff and attendance at mandatory training such as moving and handling, safeguarding of vulnerable adults, fire safety and general health and safety. Staff we spoke with confirmed these arrangements for induction.

When we carried out our last inspection in July 2016 we were told staff were also enrolled on the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. The standards cover areas such as, infection prevention and control, safeguarding adults, working in a person centred way and duty of care. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting employment. At the time we were told that any staff who did not have a qualification in Health & Social Care were being signed up immediately.

At this inspection we met with two members of the academy including the newly appointed training manager. We were advised that it had taken some time to formulate and organise the academy and this continued to develop. The introduction of the Care Certificate had been placed on the 'back burner' as other areas were being developed. The intention was to 'map' the standards in the Care Certificate over to the existing induction package. No staff at the Willows had been inducted using the care certificate although we saw that work files had been prepared for two staff. We spoke with one staff member who met the criteria for induction under the care certificate but had not been considered.

We discussed the need to fully implement and work with the standards set out in the care certificate for staff induction. This has been discussed on previous inspections at the Willows and other care homes in the Dovehaven group.

We recommend the induction of new staff fully incorporate the standards in the Care Certificate.

We discussed with the registered manager other formal qualifications in care which staff had achieved or were enrolled on. We saw that staff were undertaking accredited qualification made up of units such as, NVQ (National Vocational Qualification) or Diploma under the QCF [Qualifications and Credit Framework). With regards to formal qualifications in care the manager told us five members of care staff had obtained a NVQ in care. This was confirmed by records we saw.

We saw training certificates for courses undertaken in respect of subjects such as safeguarding adults, moving and handling, infection control and food hygiene. The registered manager told us about discussions held during staff meetings around abuse, the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and fire safety, as a way of enhancing staff knowledge. The registered manager informed us that training was provided face to face and also via DVDs and questionnaires. The training matrix sent to us following the inspection evidenced a series of on-going updates and training to support staff in these subjects.

The registered manager told us they were keen to develop areas of good practice. For example the registered manager attended a local 'dementia care' forum which met monthly and any learning was brought back to the home.

Staff support included supervision meetings conducted by the manager with individual staff. Staff we spoke with felt they were fully supported by the registered manager and could speak with the registered manager and other senior members of the staff team at any time.

During our inspection we reviewed the care of five people living at the home. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. One person we reviewed had experienced changing care needs over a space of time and these changes had been monitored by staff in liaison with the person's GP and other health professionals. The staff had been instrumental in ensuring regular assessment had taken place including continually assessing the person's mental capacity to help ensure they could consent and be involved in any rehabilitation. The current update was that the person was going for a home visit to be assed for possibly returning home; the assessment was to include social worker involvement and other health care professionals.

We saw short term care plans were instigated should a person develop a condition that required medical intervention. Medical conditions that required long term clinical intervention were recorded and treatment plans were followed by the staff. Care plans were detailed, providing a good over view of how the condition presented, the signs and symptoms and clinical care. An example of this was for a person who was receiving a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. Care records seen showed staff were following the plan of care and treatment plan.

Staff had sought advice from external health care professionals to help oversee people's health and wellbeing or if there had been a change in a person's condition. This advice had been sought at the appropriate time and their guidance followed. For example, we saw staff were working with a dietician, infection control team and speech and language therapy (SALT) team

We spoke with a visiting health care professional. They gave positive feedback regarding the care in the home and how well staff responded to any instructions or recommendations for care. We were told, "They [staff] are very efficient and always refer [people] when needed. There is good communication with the home and good liaison."

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005

(MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had applied for a number of people to be supported on a Deprivation of Liberty Safeguards (DoLS) authorisation. The applications were being monitored by the registered manager of the home. We saw that if people were on a DoLS authorisation there was a supporting care plan to reference this.

The staff and registered manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. In one example a person with varying levels of mental capacity to consent was being supported in their wish to return home with the necessary support. We saw supporting assessments and documentation which supported good practice in this area and made use of mental capacity assessments with good supporting care plans and liaison with social care professionals. The staff showed a clear understanding that the person's mental capacity could fluctuate depending on circumstance and the decision in question.

Other examples included care files showing were people had consented to their plan of care. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members].

We asked about the food at the Willows. We observed people with drinks throughout the day, cups with lids and double handles were available to support people, as necessary, to drink independently. Jugs of water and cordial were provided to people who chose to stay in their own room and were on offer in the lounge and conservatory. Drinks were served with lunch and tea, coffee or cold drinks were offered in the afternoon. One person commented, "This [cup of orange] appears in the morning; you don't have to ask."

We looked at the four weekly menus, which offered a well-balanced, appetising and varied range of meals. The chef explained that these menus were reviewed regularly in consultation with the registered manager. People living at The Willows were not consulted about this but the chef felt that their preferences and needs strongly influenced any decisions made about the menus. The chef said they spent time talking with people on a daily basis and got to know what people liked as a result. When we saw the chef in conversation with people during our visit they demonstrated familiarity with, and good knowledge of, the people living there.

We observed lunch being served both to people in the shared lounge/dining room and to people in their rooms. People sat either in the chair they were already in, with individual tables being used to facilitate this, at one of the two dining tables in the conservatory, or in their own rooms. We saw one person provided with a plate guard to further facilitate independent eating. Some people were served or supported with their food pureed.

Care staff were patient and gentle when offering support, but in some instances with minimal verbal interaction with the people who needed a lot of support.

Meals were served hot, on large white ceramic plates; portions were very generous and two people commented on this; "I've never not had enough" and "There's always plenty – too much really." All of the

people we spoke with enjoyed the meals.

Requires Improvement

Is the service caring?

Our findings

We found staff members were generally kind and friendly in their manner towards people living at the home, and in general appeared to know people quite well; relationships seemed to be positive.
However, staff seemed at times to be 'task-orientated' in that they only engaged with people when actually carrying out care. Sometimes the opportunity to communicate with people was missed.

For example we saw a carer putting a drink in front of a person without speaking to them. On another occasion a person was transferred using a hoist by two staff, neither of whom spoke with the person and explained the process.

We also noted that for one person who the carer staff spoke with, they did not use the person's name, and referred to them as 'sweetheart' and were engaged in a discussion 'over the head' of the person concerned. This person had nobody close by to talk to, although fully able to engage in conversation, no member of staff took time during our observations to talk to or get to know them despite the fact they had only recently been admitted to the home. This person was left with a drink they didn't like; although they said they liked tea, they were offered and given a cup of water.

We recommend the provider look to provide support / coaching for staff around engagement to help establish positive relationships with the people they support.

When we asked people if they were treated with kindness and compassion, responses were almost all positive, in varying degrees. Some examples of comments were: "They're kind, yes, and you get people like this [indicating a member of the domestic staff] who'll do anything for you", "Very nice – all of them are", "They're quite good, yes. I'm very happy here", "You couldn't get any better attention; the least thing I want, I get – they do too much for me, to be honest" and "Great – friendly, helpful, yes; I can't fault them."

A visitor was less positive and commented, "I feel they're [staff] lacking in warmth and friendliness; they don't speak to [person] and they haven't really made us feel welcome, as yet."

We asked what sorts of things staff did to protect people's privacy and dignity. Most people gave examples of actions staff took to ensure this; "They knock on the door before they come into your room, when they pop in to check you [at night]. I never feel that they've compromised my dignity in any way, if I can put it like that", "Well my door's usually open and they do ask most of the time [before coming in]. They will close the curtains" [if providing personal care in the room], "Yes - they always shut the curtains when I'm using the commode, things like that" and "They [staff] just walk in sometimes, but I think that's because they feel they know [person] won't mind. They should knock though, shouldn't they?"

When we spoke with staff they came across as caring and interested in their work. One staff told us about the time they had taken to assist one person with their communication by the provision of a board for writing and communicating. Staff told us that the home was very busy in the morning but staff did get time to engage with people in the afternoon; one staff said, "We can pop in and see people in their rooms."

Care plans we viewed contained evidence of people and /or their families being involved in the care planning process; this was evident through signed consent forms and records of discussion with people and families.

We saw that people had access to advocacy support if needed. One person was engaged with the local advocacy support service and was getting support regarding their finances. The local advocacy service was advertised in the home.

Good

Is the service responsive?

Our findings

We asked people how staff knew what they liked/disliked, or about their interests, and if they could choose what they wanted to do, such as activities, life choices, people they want to be with. People told us they were able to make choices. They said they could choose how and where they wished to spend their day, what meals they would like served and what time to get up and retire at night. A number of people chose to spend time in the lounge whilst others preferred to spend time in their own room.

Some examples of people's responses were; "This is my chair [indicating armchair and explaining it did not belong to them but was their preferred place to sit] and my table. I sit here so I can see out of the windows", "I always sit here and I have my lunch here", "Oh yes [can choose]. I prefer to stay in my room most of the time but I can go downstairs if I like" and "I can choose to go downstairs whenever I like; upstairs or downstairs as I wish."

One person was being visited by a relative and was served lunch at 1pm by preference and differently from anyone else. The meal was served piping hot and relatives reported that this request was 'not a problem' when put to staff.

Care records were completed, for example people's food and fluid intake and positional change in when being nursed in bed. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care.

Care plans were specific to the individual and there was reference to people's life history to get to know people's social care needs in more detail. These records, along with staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs.

Staff were aware of the importance of these records for monitoring people's health and welfare. We looked at a sample of these records and they were kept up to date by the care staff. For one person we discussed with the registered manager further information to be recorded around the frequency of a person's change of position within their plan of care to evidence the regular position changes which staff were undertaking. The registered manager said they would action this. The person concerned appeared comfortable in bed and staff checked on their position and comfort every two hours. We saw care plans were regularly reviewed and people were consulted periodically about their care.

We asked what sorts of things the home provided to keep people interested, active or involved. Several people referred to outings and we were aware of a new activities coordinator in place and beginning to ask for people's views about preferred activities. One person commented, "The coach [minibus] comes and we go to various places. We went to the zoo once. And we've been to a big lake – we sat round the lake and watched the birds taking off." Another person told us, "When there's anything on I go downstairs – singing

and that. They have an outing most Monday afternoons; I've been on most of them and enjoyed them" and " On Monday we went to the Leisure Lakes; the week before that a trip round the local villages."

We spoke with the new activities coordinator who told us they would be spending 12 hours weekly at the home. Currently they were engaged in getting to know the people living at the Willows with a view of organising more personalised activities.

People had access to a complaints procedure and this was available to people within the home.

None of the people or the relatives we spoke to were aware of any formal or informal processes for gathering views and none knew of a complaints policy. However, nobody living at The Willows felt this was an issue and none had any complaint to make; several said they would simply speak up. Two relatives had minor concerns and said they felt happy to discuss these with the registered manager or other people in charge of the home. One person commented, "If I had anything I wanted to tell, I'd tell the person in charge on the day. I think they'd sort it out." Another commented, "I have nothing to complain about and if I did, I'd speak to [manager]."

A system was in place to record and monitor complaints and those we viewed had been responded to appropriately in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

As part of the feedback to the registered manager and senior managers we identified some key areas of the homes management where improvements were needed. Most notably the auditing processes regarding medication management. Existing audits were not fully developed and had not identified the issues we found in administration of medicines. Similarly, standards around induction training for staff incorporating the Care Certificate were not fully formed and consistent although previously discussed and reviewed with the provider.

The management team have, since our feedback been responsive and acted on these identified areas of concern. For example the register manager advised us, "The new plans are currently being rolled out to incorporate the Care Certificate running alongside the induction program within the company." Also, with respect to the medication recording issues, "All thickeners will be stored safely and staff have been informed of correct procedures with regard to documentation being completed correctly." Medicine audits had been revised to help ensure these issues were routinely checked and monitored.

We found the registered manager and deputy exposed a positive ethos of care in the home. This was provided by the leadership of the registered manager who evidenced good clinical skills and a solid knowledge base. Staff, people living at the Willows and visitors all spoke positively about the registered manager who was described as supportive, open and a consistent presence in all areas of the home.

The registered manager told us they felt supported by the providers development of the governance arrangements and support which had helped them to develop standards in the home. The registered manager was open and we saw they could reflect positively on the feedback we gave as we went through the inspection.

There was a clear management structure for the service from the providers, senior managers registered manager and deputy manager. There was also a training officer for the provider. The provider and senior managers were present during the inspection. The providers visited the home regularly and we saw they were integral to the monitoring and oversight of the home.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety [required further improvement], care planning and routine checks for health and safety regarding the environment and infection control.

Senior managers had also conducted some audits including infection control and health and safety six monthly audits. We were advised that once the six monthly audits were completed they are forwarded to the regional managers who review with the home manager and address the shortfalls identified in the action plan and attach time scales.

A senior manager advised us, "The regional managers will oversee the audits carried out by the home

manager – we need to show these at our provider meetings every month. Everything is a lot tighter and robust now and everything is being checked to ensure the quality of care we are providing"

The service had also developed good systems for getting feedback from people living at the home and their relatives as well as staff. We saw a series of surveys and meetings aimed at seeking feedback about the home. For example a recent food survey [November 2016] collected positive comments regarding the meal time provision. The last relatives / resident survey carried out in November 2016 again gave positive feedback and a good overall satisfaction rating regarding the home generally. We saw that issues picked up had been addressed by the registered manager.

These systems had helped the registered manager to focus on some immediate issues for improvement. The registered manager commented that overall "Communication was good."

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for the Willows was displayed for people to see.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered safely. Medication administration records [MARs] were maintained but some recording of medicines were not clear or consistent.