

Hampshire County Council

Willow Court 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?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection was unannounced and took place on the 27, 28 and 29 September 2016.

Willow Court provides nursing, short term respite and residential care for up to 66 older people. The home accommodates people with a range of needs, including those living with dementia, epilepsy and diabetes. At the time of our inspection 63 people were living in the home.

Willow Court is a purpose built nursing home situated in the grounds of Andover War Memorial Hospital. The home comprises of single occupancy bedrooms with ensuite toilet and hand washing facilities. The home is over two storeys with the first floor accessible to those with mobility needs via a lift. Willow Court is divided into seven distinct living areas, Acacia, Juniper, Saffron, Rosemary, Jasmine, Primrose and Lavender with appropriate signage to make it easier for those with dementia to navigate independently. The building is situated around a secure garden which is accessible to people and visitors by double opening doors on the ground floor.

There was a registered manager at this location. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the HSCA and associated Regulations about how the service is run.

We make recommendations to signpost providers to potential action they can consider to help them improve the quality of the service they provide to people who use it. We follow up recommendations at our next inspection. At our last inspection on 19 and 23 January 2015 we made two recommendations where the provider could take action. These concerned the documentation and practice regarding 'as required' medicines and pain assessments and ensuring that activities were offered which meet the needs and wishes of the people using the service.

During this inspection we saw that appropriate documentation was in place to provide guidance to staff in peoples care plans about the use of as required medicines. We saw that people were encouraged to participate in activities which better suited their needs. However we saw activities staff were also completing other functions within the home. We have made a recommendation that the role of the activities coordinator is reviewed to ensure they remain dedicated and able to complete the role they are employed to fulfil.

The provider did not always ensure that effective quality assurance and auditing systems were in place in order to drive improvements in the quality of the service people received. Action was not always taken to rectify where shortfalls in service provision were found.

There were sufficient numbers of staff deployed to meet people's individual needs. Processes were in place to regularly review the required level of staff to ensure this remained appropriate.

The home provided both long term and short term care for people including those living with dementia and the environment was designed and decorated in a way to support people to move around the home safely enabling them to remain independent. Corridors were wide and well lit with contrasting different coloured handrails to aide people who were able to walk. Appropriate signage helped people to orientate themselves around the home.

Relatives of people using the service told us they felt their family members were cared for safely. Staff understood and followed the provider's guidance to enable them to recognise and address any safeguarding concerns about people.

People's safety was promoted because risks that may cause them harm had been identified and guidance provided to manage these appropriately. People were assisted by staff who encouraged them to remain independent. Appropriate risk assessments were in place and regularly reviewed to keep people safe.

Thorough recruitment procedures were completed to ensure people were protected from the employment of unsuitable staff. Induction training for new staff included a period of time working with experienced colleagues. This ensured staff had the skills and confidence to support people safely. Staff were happy to raise any concerns with their colleagues and senior staff and received regular supervisions. Staff told us they felt supported as a result.

Contingency plans were in place to ensure the safe delivery of care in the event of adverse situations such as a loss of accommodation as a result of fire or flooding. Fire drills were documented and practiced to ensure people were kept safe.

People were protected from the unsafe administration of medicines. Nurses responsible for administering medicines had received detailed training and were subject to competency assessments to ensure people's medicines were administered, stored and disposed of correctly.

People received sufficient food and drink to maintain their health and wellbeing. Snacks and drinks were encouraged between meals to support good nutrition and ensure people remained hydrated. People assessed as requiring a specialised diet, for example a pureed and diabetic diet, received these.

People were supported by staff to make their own decisions. Staff demonstrated that they complied with the requirements of the Mental Capacity Act 2005 when supporting people. This involved making decisions on behalf of people who lacked the capacity to make a specific decision for themselves. Documentation showed people's decisions to receive care had been appropriately assessed, respected and documented.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Appropriate applications had been submitted to the supervisory body to ensure that people were not being unlawfully restricted.

The staff and manager promptly engaged with other healthcare agencies and professionals to ensure people's safety and wellbeing.

Staff demonstrated they knew and understood the needs of the people they were supporting and people told us they were happy with the care provided. The manager and staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People had care plans which were personalised to their needs and wishes. They contained detailed

information to assist staff to provide care in a manner that respected each person's individual requirements. Relatives told us they were encouraged to be involved at the care planning stage, during regular reviews and when their family members' health needs changed.

People told us they knew how to complain and would be confident that the registered manager would take the appropriate action to deal with their concerns. Procedures were in place for the registered manager to monitor, investigate and respond to complaints in an effective way. People and relatives were encouraged to provide feedback on the quality of the service during regular care plan meetings and resident and relative meetings.

The provider's values were displayed within the home. We could see these standards were evidenced in the way care was delivered.

The registered manager and staff promoted a culture which focused on providing care in the way that staff would wish to provide to their family members. The registered manager provided strong leadership and had fulfilled the requirements of their role as a registered manager. The registered manager had informed the CQC of notifiable incidents which occurred at the service allowing the CQC to monitor that appropriate action was taken to keep people safe.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we asked the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

The provider had a documented process in place to ensure that sufficient numbers of suitably qualified staff were deployed. However some people told us they sometimes had to wait to receive assistance. The provider was in the process of recruiting additional bank staff to provide continuity of care for people.

People were safeguarded from the risk of abuse. Staff were trained and understood how to protect people from abuse and knew how to report any concerns.

There was a detailed recruitment process in place. Staff had undergone thorough and relevant pre-employment checks to protect people from the employment of unsuitable staff.

Risks to people had been identified, recorded and detailed guidance was provided for staff to manage these safely for people.

Medicines were administered safely by nurses whose competence was assessed by appropriately trained senior staff.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were able to eat and drink enough to maintain their nutritional and hydration needs however processes in place to ensure food remained in date and was served at a suitable hot temperature were not always completed fully.

People who required a specialised diet received the food in an appropriate way to meet their health needs.

People were supported by staff who had the most up to date knowledge available from detailed care plans to best support their needs and wishes.

People were supported to make their own decisions and where they lacked the capacity to do so staff ensured the legal

Requires Improvement ●

requirements of the Mental Capacity Act (MCA) 2005 were met.

People were supported by staff who sought healthcare advice and support for them as required.

The home design supported people living with dementia. The decoration supported those living with poor eye sight associated with old age and dementia to move around the home independently.

Is the service caring?

Good ●

The service was caring.

People told us that staff were caring. Staff had developed positive and caring relationships with people.

People were encouraged to participate in creating their personal care plans. Relatives and those with legal authority to represent people were involved in planning and documenting people's care. This ensured that people's needs and preferences were taken into account when developing their care plans.

People received care which was respectful of their right to privacy and dignity whilst maintaining their safety.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People were afforded opportunities to participate in activities which met their needs however activity staff were used to fulfil other roles which could limit the amount of time available to support people with their activity needs.

People's needs had been appropriately assessed. Staff reviewed and updated people's care plans on a regular basis and when people's needs changed.

There were processes in place to enable people to raise any issues or concerns they had about the service. Any issues, when raised, had been responded to in an appropriate and timely manner.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

The registered manager and provider had quality assurances

processes in place however these were not always completed regularly and in line with the provider's guidance. Where shortfalls had been identified appropriate improvements had been made to improve the quality of the service people received.

The registered manager and senior staff promoted a culture which placed the emphasis on care delivery that was respectful and delivered by staff who felt they were caring for their own relative.

Staff were aware of the responsibilities of their role and felt supported by their colleagues. Staff told us they were able to raise concerns with the registered manager and were confident they would be addressed.

Willow Court 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 function. 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 inspection took place on the 27, 28 and 29 September 2016 and was unannounced. The inspection was conducted by two 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; on this occasion they had experience of family who had received residential care. The Expert by Experience spoke with people using the service, staff, their relatives, observed mealtime sittings and interactions between staff and people living at the home.

Before our inspection we looked at previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to send us by law. The provider also completed a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked this information as part of our inspection.

During the inspection we spoke with eight people, nine people's relatives and two visitors. We spoke with the registered manager who was also a registered nurse, the deputy manager also a registered nurse two further nurses and seven health care assistants (who will be referred to as staff throughout this report). We pathway tracked twelve people, which meant we reviewed their care plans, daily notes and medication administration records to review the care they received. We also looked at staff related documentation which included six staff recruitment files, staff training records and staffing rotas for the dates 21 August to 28 September 2016.

Documentation relating to the running of the home was reviewed which included quality assurance audits and the resulting action plans, the provider's policies and procedures, complaints and staff and relative meeting minutes. During the inspection we spent time observing staff interactions with people including

during two lunch time sittings and participation in activities.

Is the service safe?

Our findings

At our last inspection on 19 and 23 January 2015 we recommended the provider reviewed their practice regarding 'as required' medicines and the regular use of pain assessments. At this inspection we found that the provider had taken positive steps to address the recommendation made.

People living at the home received their medicines safely. Nurses were responsible for administering medicines. Records showed that medicine administration records (MARS) were correctly completed to identify that people received their medicines as prescribed. Nurses were also subject to regular competency assessments as part of the provider's quality assurance processes to ensure medicines were managed and administered safely. There were policies and procedures in place to support nurses to ensure medicines were managed in accordance with current regulations and guidance.

Some people living at the home were receiving medicines which are known as PRN or 'as required' which includes analgesics, sedatives and other medicines to manage people's pain. These are medicines that are not routinely required and may only be needed occasionally. Peoples MARS included a PRN protocol for nurses so they were able to see when PRN medicines were most appropriate, and the dosage that could be given.

For example, people's MARS showed when they were in receipt of medicines for pain relief, clear guidance was provided as to when it could be administered and the levels of which could be given and for how long. For people who were unable to verbally communicate a pain assessment tool provided clear guidance to staff to assess changes in people's wellbeing against a number of areas. This was to assist in identifying when PRN was required. This included identifying changes in people's facial expression, their body language and any behavioural change for example. This made it clear to nurses when additional medicines were required to meet people's needs.

We observed a medicines round where the nurse appropriately supported people to take their medicines as required. The nurse also routinely asked if people were experiencing any pain and wished to take any PRN medicines.

Medicines were stored, administered and disposed of correctly which included those which required refrigeration to remain safe. The temperatures of drugs storage locations were routinely completed and documented to ensure they remained suitable for use.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971, these are called controlled drugs and they have additional safety precautions and requirements. Controlled drugs stocks were audited and documented daily by the nurses to check that records and stock levels were correct.

We received mixed views from people, relatives and staff if there were sufficient numbers of staff deployed at Willow Court. One person told us, "There are not enough staff at times, I have to wait a long time sometimes for help, sometimes it can be 15 – 20 minutes which is a long time". A relative told us, "There are not enough

staff...residents are having to wait...long waits only exacerbate the situation". One member of staff said, "I enjoy working here but it can be busy with all the double ups".

However whilst people, staff and relatives told us staff were busy all said they and their family members were receiving all the care they required. They acknowledged that on occasions where staff were supporting more urgent needs there could be a delay before this care was received however it was always provided. One relative told us, ""Staff are on hand even if you have to wait a while sometimes". One person told us, "There are less staff at nights...but I do get a cup of tea in the night if I want, I had a cuppa at 4am and 5am last night".

Relatives told us staff were around at all times and could see support when it was required. One relative told us, "(my family member) Is safe, there are staff around to help when they need it...they (family member) have been here 2 years and there are always staff around when you visit". Another relative supported this view and told us, "No (no care is being missed) not really, they do everything for her...all is being done."

From our observations there seemed to have been sufficient staff numbers; for example, we did not notice any people being left waiting to be attended to, and on the occasions when we heard the call alarms being sounded these appeared to be responded to quickly.

The registered manager routinely assessed whether sufficient numbers of staff were deployed to meet people's needs. This assessment was completed on the number of people living at the home and how many required two staff to support them with all aspects of their personal care. As a result they had identified the number of staff required to meet people's needs. These consisted of four nurses, 14 members of staff plus an additional member of staff to provide people with drinks working the morning. In the afternoon the minimum staffing identified as required was three nurses and fourteen members of staff. Overnight two nurses and five staff were the minimum staffing levels required.

The registered manager was able to review and change staffing numbers requesting additional if people's needs changed or their health deteriorated. We saw, for example, staffing levels were appropriately adjusted when people required one to one support with their daily living. The registered manager responded to feedback from nurses and managerial staff to identify when a new staffing level review was necessary.

Where shortfalls had been identified due to annual leave, sickness or maternity leave the home used agency or bank staff to support existing staff members. The registered manager acknowledged that maintaining staff levels was a challenge due to career progression opportunities available elsewhere. However the provider had recently closed an advert for the recruitment of casual bank staff. The recruitment of bank staff would enable the home to minimise the numbers of agency staff used to support existing staff members and ensure people received care from known and familiar faces.

People and relatives we spoke with told us that people living at Willow Court were safe. One person told us, "I do feel safe". Relatives agreed, one told us, "Oh yes, definitely (family member is safe)," another said, "Yes, I do feel he (family member) is safe here, he's not had a fall since June 2015". Another relative told us, "Oh definitely, definitely (family member is safe), I think to be frank they're safer here than they are in hospital, by a very long order".

Detailed recruitment procedures were followed to ensure staff employed had the appropriate experience and were of suitable character to support people safely. Staff had undergone detailed recruitment checks as part of their application and these were documented. These records included evidence that pre-employment checks had been completed including obtaining written previous work and personal character

references. Recruitment checks also included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent the employment of staff who may be unsuitable to work with people who use care service. Nurses who wish to continue to practice in their role must register with the Nursing and Midwifery Council to keep their skills and knowledge up to date. We could see that nurses were meeting the requirements of their role and regularly renewing their registration to evidence they remained competent to continue. People were kept safe as they were supported by staff who had been assessed as suitable for the role.

Staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Staff were also able to describe the physical and emotional symptoms people suffering from abuse could exhibit. Staff were aware of their responsibilities to report any safeguarding concerns. The provider's policy provided guidance for staff on how and where to raise a safeguarding alert which included contacting the local social services safeguarding teams. Staff received training in safeguarding vulnerable adults and were required to refresh this training annually.

Where staff felt unable to raise concerns in person the provider had a whistleblowing policy to support staff to raise concerns anonymously. Records showed that when concerns had been raised anonymously they had been investigated thoroughly. Action had then been taken where appropriate to address areas where required, for example, when issues had been raised regarding the provision of care for one person. The registered manager had responded immediately to the concern raised speaking with staff and completing unannounced spot checks with the deputy managers. These had occurred during the night time period when it was believed inappropriate care was being delivered. The allegations were not substantiated. People were protected from the risks of abuse because staff understood the signs of abuse, the actions they should take if they identified these and the provider responded appropriately to issues raised.

Risks to people's health and wellbeing were identified and guidance provided to mitigate the risk of harm. All people's care plans included their assessed areas of risk for example, regarding falls, moving and handling and the use of bed rails. Risk assessments included information about the action staff needed to take to minimise the possibility of harm occurring to people. For example, some people had restricted mobility due to their physical health needs. Information was provided in these people's care plans which provided guidance to staff about how to support them to mobilise safely around the home and when transferred. Additional risk assessments were completed when required to manage new risks identified to people's safety. These risk assessments were reviewed monthly. This ensured that all current risks were identified and appropriate action documented for staff to take to mitigate this risk as soon as this change in need had become known. Staff knew these risks and were able to demonstrate when supporting people how they ensured people's safety. Risks to people's care were identified, documented and staff knew how to support people's needs safely.

When accidents and incidents occurred these were documented fully and immediate and longer term actions identified to try to minimise the risk of a reoccurrence. For example one person was found to have an unexplained injury whilst their personal care was being delivered. This was treated immediately by the nurse with the appropriate medical treatment and a short term care plan put in place to ensure the injury was monitored and treated effectively. The incident was investigated fully and lessons identified post incident were documented and shared with staff to minimise the risk of a similar injury occurring again. Accidents and incidents were documented, reviewed and actions taken as a result to mitigate the risk of future harm occurring.

There were contingency plans in place to ensure people's safety in the event of an untoward event such as

accommodation loss due to fire or flood. The business continuity plan was situated in an emergency 'grab bag' situated by the front door to allow for easy access by staff and emergency personnel. This provided guidance of the steps to take in the event of an emergency to ensure people were kept safe. Staff also took part in fire safety and fire drill training. If an evacuation were required this guidance detailed that the registered manager would move people to the providers other homes in the county. These plans allowed for people to continue receiving the care they required at the time it was needed.

Is the service effective?

Our findings

People and their relatives we spoke with were positive about the ability of staff to meet their and their family members care needs. People said that they felt staff had sufficient knowledge and skills to deliver their care. One person we spoke with told us, "They (staff) look after me very well". Relatives agreed, one relative said, "He (family member) is well looked after and he gets such lovely care here", another relative told us, "I know he's looked after, they look after him so well here".

People and relatives were mainly complimentary about the food provided. One person told us about the food, "I had a good breakfast and there is a choice that we can have...The food is really good with a choice of main and vegetables too, there is a choice of desserts which includes cheese and biscuits too...I get plenty to drink and you can make drinks in the lounge too". A relative told us, "The food is very, very nice in fact I eat here myself" however one person we spoke with told us the food was, "Mediocre".

Willow Court did not have its own fully functioning kitchen; the home was linked by internal corridors to the Andover War Memorial Hospital who were contracted to provide food to the home. Each unit in the home had a separate dining room/lounge/kitchenette area which contained a fridge, kettle, microwave and hot drink making facilities. There were store cupboard ingredients such as bread and jam and biscuits. The breakfast, dinner and tea time food was provided by the hospital catering team. People were offered a variety of choices for the meals and were able to identify the size of portions they required as well as whether or not they required a diabetic diet. People were offered both hot and cold options at all meal times. People were supported by staff, where necessary, to select their menu choices the night before however if they changed their mind on the day alternatives such as jacket potatoes, fish and chips, omelette and sausages were available.

Food was brought to Willow Court, in the main on heated trolleys however we did observe a non-heated trolley being used to serve a warm meal during the inspection. We saw people were provided with both their main course and their hot pudding at the same time. This meant by the time people were ready to eat their pudding it may have no longer been warm.

At a resident meeting in July 2016 it was identified that staff were not always heating plates prior to serving food so the food was often cold by the time it was eaten. We could not see that action had been taken in response to this. A quality assurance audit completed in August 2016 by the provider identified that the temperature of all food served should be above the minimum temperature levels required in the log book and that food stored in the units fridges must be in date. An action plan was put in place which identified that food temperatures should be tested and documented accordingly. However we could not see that this was happening.

Each individual unit in the home had a 'Food Safety Servery Records Book' which covered the period of January 2016 to December 2016. These stated that the registered manager must review and sign the book every month and a service manager must review every six months and sign and date. These servery books continued that the fridge temperatures much be checked twice daily and that hot food should be checked

twice a day, on two days a week. This was to ensure the temperature at the point of serving was above 63 degrees but ideally not below 70 degrees. Of the five servery books viewed, none had been completed as documented as necessary.

From the 1 August 2016 to September 2016 the fridges should have been checked a total of 118 occasions however the actual testing was only completed between 45 and 52 times. This meant that items which were being stored within such as yogurts, microwave ready meals, milk and jam were at risk of being stored at an unsuitable temperature. This could lead to food spoiling creating a risk to people's health. In one of the fridges approximately 5 litres of milk with the use by date of the day prior to the inspection were still in use. These were immediately removed and brought to the registered manager's attention. All other consumables were within their use by date period.

From the 25 July 2016 to 28 September 2016 two hot meals should have been checked twice a day, twice a week which accounted to a total of 76 occasions. However this actual testing was only completed between 32 and 54 times. This meant that people were at risk of receiving food which was not of an appropriate temperature. The registered manager told us kitchen assistants were supposed to complete the documents which were reviewed during infection control audits. However we could not see that the documented action was being taken to ensure people were receiving food which was of an appropriate temperature to their preferences.

The provider did not have an effective system in place to monitor and assess the risks to the health and safety of the people who use the service taking action where necessary to address and rectify any shortfalls. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People were assisted by staff who received a thorough and effective induction into their role. New staff were required to complete an induction called 'Stepping forward, stepping back'. This involved training and completing a workbook which focused on key subjects such as moving and handling, safeguarding, and infection control for example. These workbooks supported staff during their induction and provided opportunities for the registered manager to test staff understood the learning and retained their knowledge. This induction was then followed by a period of shadowing experienced staff to ensure that they were competent and confident before supporting people. Nurses were also afforded opportunities to further their training by being supported to undertake mentoring courses. All staff and nurses were supported by the provider to seek additional training allowing them to continue to further their knowledge and for nurses to retain their professional accreditation to remain registered.

People were assisted by staff who received support in their role. There were documented processes in place to supervise and appraise all staff to ensure they were meeting the requirements of their role. Supervisions and appraisals are processes which offer support, assurance and learning to help staff develop in their role. The registered manager said that supervisions were due to occur every six to eight weeks. However not all staff had received their supervision within this timescale. Records showed that all staff had received at least two supervisions since February 2016 however these had been repeated in intervals of between two and five months. The registered manager had delegated some staff supervisions to nurses and the deputy managers to ensure that these were completed within the provider's required timescale. A detailed and documented supervision schedule was in place for all staff to receive supervision within the specified times however more time was required for this process to be embedded and sustained in working practices.

Despite not receiving documented supervisions and appraisals in line with the provider's timescales all staff we spoke with told us they were able to speak to their colleagues, the nurses, deputy managers and

registered manager at any time if they required additional support or guidance. One member of staff said "We have good supervisions and appraisals, we can raise issues and nurses are supportive and we don't have to wait for a supervision or appraisal to raise concerns. The nurses will come and ask us about concerns."

People's freedom was not unlawfully restricted without the appropriate authorisation being sought. The Mental Capacity Act 2005 (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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager and deputy manager showed an understanding of the DoLS which was evidenced through conversations and the appropriately submitted applications and authorisations.

Records showed that decision specific mental capacity assessments and accompanying best interest decisions were made in relation to a number of aspects relating to people's personal care needs and wellbeing. Best interest decisions are made when people no longer have the capacity to make a specific decision about their life or care. The provider promoted the use of Independent Mental Capacity Advocates (IMCA's) for people unable to make key decisions in their life. This is a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views. Records showed that the registered manager had responded appropriately when people were no longer able to make decisions which could affect their wellbeing and did not have relevant persons to act on their behalf. This included involving IMCAs as well as health and social care professionals in best interest decisions regarding people's ability to consent to the care they received.

Consent to care and care plans were agreed with people, their relative or nominated person such as those with a Power of Attorney (POA). A person who has been provided with POA is there to make decisions for people when they are unable to do so for themselves. This process included involving those with a POA in assessing people's care needs before moving into Willow Court, in care plan reviews and assisting in making best interest decisions. These meetings were held when people's physical and mental wellbeing were at risk of deteriorating due to the person not being able to provide their consent to a certain aspect of care. People were supported to have their views known and the provider ensured those with appropriate POA were involved in all aspects of people's care.

People were supported to maintain good health and could access health care services when needed. Processes were in place to ensure that early detection of potential illness could be identified by regular review of people's risk assessments and care plans. Where required people were supported to seek additional healthcare professional advice which included seeing dieticians, for example. When advice from healthcare professionals had been provided we could see this had been documented and staff had taken appropriate action to ensure this guidance was followed.

Care plans detailed how to recognise the signs of an impending health related issue and what action to take as soon as one of these incidents were recognised. For those living with catheters we could also see that guidance was provided for all staff on how to make sure these remained operational and how to treat any

problems identified during their use in order to minimise the risk of infection for people using. There was evidence of referral to and collaborative working with healthcare professionals, families, people and staff.

Willow Court was a purpose built nursing home which had been designed to meet the needs of older people and specifically decorated to support people living with dementia. We saw that the environment had been adapted to support people to live as independently as possible. The corridors were wide and naturally lit with the addition of wall lighting to ensure people with limited eyesight often associated with dementia could see clearly. Handrails were in place and in contrasting colours to the walls to aide people to find physical support as they mobilised. Toilets, bathroom doors and doors leading to communal areas such as the lounge/dining rooms had pictorial signage to make identification easier for people. Door frames associated with different areas such as people's rooms and bathrooms were also different colours to help people associate colours with their living environment.

Is the service caring?

Our findings

People and relatives we spoke with told us that support was delivered by caring staff. One relative wrote in the home's newsletter, 'My wife is resident at Willow Court and is well looked after by a large caring and loving staff who go beyond their duties to help the residents and their relations'. A relative told us, "Everyone is treated with dignity and respect, even if they (people) can't speak; they (staff) will talk to them and chat away whilst they are with them". A visitor said, "The residents are treated very well, kindly and considerately."

Professional, compassionate and caring relationships with people had been developed by staff. This was supported by care plans which had been written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. Care plans also included information and guidance for staff when interacting with people who were not always able to clearly verbally communicate. This included using non-verbal gestures and when specific care should be given to people suffering from confusion as a result of living with dementia. One care plan read 'Staff should sit and talk with her whilst holding her hands; she doesn't like to be left alone'. Staff recognised the importance of this communication and ensured that when people were not able to verbally communicate they were still included in conversation. One member of staff told us, "Even if residents don't respond, I will talk to them as they can still hear and feel even if they can't communicate back". Staff followed guidance provided and took time greeting people using their preferred name, talking about their families and their participation in recent activities as well as giving people the additional time and support to express their needs.

Staff knew the people they were supporting because care plans included information about what was important to them such as their family relationships and what help they required to support them and when. People's care plans included a 'Who and what is important to me' document. These detailed the activities and people who were important to them and the support they required in order to maintain these relationships and interests. For example one person identified that it was important to them that they were able to continue practicing their religion and listen to classical music. We could see the home invited church services to be conducted in the home which all were encouraged to attend. Staff had also ensured this person was able to listen to their radio at all times of the station of their choosing. Care plans assisted staff by enabling them to have an understanding of people's needs, preferences and the support they needed to remain happy. We could see that people's wants were known and people supported in the way they wanted. We could see, for example, that people were respected by having their appearance maintained. Staff assisted people to ensure they were well dressed, clean and offered compliments on how they looked. Care plans provided staff with a detailed insight into people's wants and needs which we could see were followed during the inspection.

Staff were knowledgeable about people's personal histories and preferences and were able to tell us about people's families and previous work lives. Conversations between all staff including housekeeping and activities staff, with residents showed a personalised knowledge of people and their lives and were lively, comforting and engaging. All staff in the home took time to engage and listen to people. Staff spoke fondly of the people they supported and were able to discuss how they had developed positive relationships.

People were treated with dignity as staff spoke to them at a pace which was appropriate to their level of communication. Staff allowed people time to process what was being discussed and to respond appropriately.

People who were distressed or upset were supported by staff who could recognise and respond appropriately to their needs. Staff knew how to comfort people who were in distress. Staff were able to evidence they knew how to support people when they were experiencing a period of a low mood. Staff told us they had the time to be able to spend with people if they were feeling sad or upset. All the staff we spoke with were able to describe how they would support people in a caring way giving people the time and reassurance they required until they were no longer feeling unhappy.

Where appropriate, physical contact was used as a way of offering reassurance to people. A relative told us about the staff, "They (staff) are very, very (caring) it's their whole attitude and friendliness, they'll stop and speak to patients if they've got the time, they rub people's arm and their sort of whole attitude is like a friend looking after them". We saw that staff used touch support to interact with people to engage with them. When communicating with people staff would lower themselves to eye level to ensure that people were engaged in conversation. Staff would also often gently place a hand on people's arms to communicate that they were to be engaged in conversation. We saw that people were comfortable and actively sought this physical contact with staff.

People were supported to express their views and where possible involved in making decisions about their care and support. Staff were able to explain how they supported people to express their views and to make decisions about their day to day care. This included enabling people to have choices about what they would like to wear, eat and drink and where they would like to spend their time.

People and relatives told us they were treated with respect and had their privacy maintained at all times. One relative told us, "Staff respect his (family member) privacy and always treat him with dignity and respect...he is encouraged to be independent but supported where necessary. He washes his own cup up which staff allow". Staff were responsive and sensitive to people's individual needs whilst promoting their independence and dignity. Staff were able to provide examples of how they respected people's dignity and treated people with compassion. People's care plans provided specific guidance on how to support people in a way that was mindful and respectful of people's dignity which was followed. Staff were seen to ask people before delivering or supporting with the delivery of care.

People had been supported to ensure their wishes about their end of life care had been respected and documented accordingly. Care plans provided personalised information for people regarding the support they required, their wishes about where they wanted to be at the end of their life and who they wanted present when that moment came. When people were due to receive end of life care they would be appropriately supported by staff using the 'Thinking ahead' approach. This is part of a gold standards framework for advance care planning. Advance care planning is a structured discussion with people and their families about their wishes and thoughts for the future. Advance care planning is a key means of improving care for people nearing the end of their life and enabling better planning provision of care, to help them die in a place and the manner of their choosing. Evidence showed that when people were due to receive end of life care they would be doing so with all the appropriate support from staff and healthcare professionals with their end of life wishes being respected.

Is the service responsive?

Our findings

At our last inspection on 19 and 23 January 2015 we recommended the provider reviewed the activities offered to help ensure they met the needs and wishes of the people using the service. At this inspection we found that the provider had taken positive steps to address the recommendation made providing a range of activities for people to participate in however further improvements were still required.

People and relatives mainly spoke positively about the activities provided however during the inspection we saw activities staff completing additional tasks which meant they were not in a position to support people. This meant there was the risk of less time being made available to ensure all people were able to participate in activities of their choosing.

The home had three activities coordinators who worked differing shifts in order to provide activities seven days a week, morning and afternoon, however they were often used as additional staff to complete other duties which took them away from the home. During the inspection we noted that on two occasions the only available activities coordinator was due to or had collected medicines from the local pharmacy. Activities staff were also involved in taking people on external healthcare professional visits and supporting people by collecting shopping. This was confirmed with by relatives we spoke with. One relative told us, "The activities coordinator will sit and chat with the residents for 10 minutes if she has the time...they (activities coordinators) get pulled off and they have to take patients to outpatients, doctor, they have to get things from the pharmacy". The documented role of the activities coordinator included supporting people to attend external appointments as well as conduct other tasks to support staff. This included attending to tasks which took them away from the home.

The registered managers 'Walk the Floor' quality assurance process documented that activities staff were also used to escort people to their appointments. This would include occasions where only one member of activities staff was available to provide activities for all the people living at the home. When these occasions arose we saw the entire staff team attempted to support people with their social needs. However this included staff who had not received specific training in activities support in order to provide the most suitable activities schedule for people living in the home. There was a potential risk that people may not receive the specific and dedicated social interaction they require.

We recommend that the provider monitor and review the deployment of activities coordinators to ensure their primary focus remains with the provision of activities.

On 24 August 2016 the cleaner assisted in providing activities as no activities staff were working due to leave and illness. We could see the cleaner was a well-liked member of staff with people living in the home and happily engaged in conversation with them as they passed. The cleaner also regularly brought her dog to the service which was seen to bring joy to people during the inspection. In addition the home also had a cat which the residents often interacted with providing them with a focus for their attention. During the inspection we saw that people who were not always willing to engage with others would do so with the home's cat. Using pets in this way provided interest and a comforting interaction for people.

Staff were aware of the risk of people suffering social isolation and took steps to ensure people received one to one attention where possible. This included provided stimulation to those being nursed in their rooms who were otherwise at risk of limited interaction. During the inspection we saw a member of staff provide hand massage and use a light machine to project images onto the ceiling of one person who was unable to participate in group activities. This brought joy and comfort to the person in their room who was unable to verbally communicate but responded positively by smiling at this personalised interaction.

Activities offered in the home included internally provided events and outside volunteers and acts to interest people, the home also sought to involve family members in activities provided. Recently completed activities included a Queens Garden Party and an International Day both events which were visited and participated in by people, friends, family, staff and the local Mayor. Relatives spoke positively about the events which had been provided.

Care plans detailed people's 'Likes and Dislikes' which include people's preferences regarding the activities provided and how they wished to spend their leisure time. Care plans also detailed people's hobbies and previous enjoyments to help staff to encourage people to participate in as broad a range of social activities as possible. One person's care plan stated that they liked being visited by a support group of people with lived with similar sensory impairments. During the inspection we noted that this person was visited by the group they enjoyed associating with.

The home also invited volunteers to assist in providing additional activities for people. We saw that family members volunteered their time and local charities were also involved to ensure people had sufficient activities to participate in meaningful activities. Volunteers participated in a range of activities including, arts and craft, poetry, music and gardening activities.

Where possible people were engaged in creating their care plans. Where people were not able or willing to engage in creating their care plans staff ensured that other people with a close relationship, interest and knowledge of the persons wellbeing were actively involved. Nominated friends and relatives were encouraged to contribute to the assessment and the planning of the care required to ensure it met their family member's needs. This process including inviting these individuals to be involved in reviewing the care provided regularly in accordance with their wishes, for example, monthly, six monthly or yearly.

People's care needs had been assessed and documented by the nursing or managerial staff before they started receiving care. These assessments were undertaken to identify people's support needs and develop care plans outlining how these needs were to be met. People's individual risk assessments were reviewed monthly to ensure that any changes in people's needs were identifying in a timely manner and updated where appropriate.

Where reviews identified a change in need which presented a new risk to someone's wellbeing this was appropriately documented. For example, during a monthly review it was established that a person was newly at risk of acquiring a pressure sore. The persons care plan was updated to reflect the identified new risks and the action to be taken to prevent a deterioration in their health. A short term care tissue viability care plan was put in place which accompanied this person's care plan to act as a prompt for staff to remain vigilant. This ensured appropriate guidance was given to staff allowing them to provide care to keep this person safe and maintain their wellbeing. People were receiving care which was reviewed regularly to ensure it remained relevant to their needs.

Handovers between staff were held at the change of shift. These were held between the nurses who then shared this information with care staff. The handover contained specific and detailed information in relation

to people's needs such as changes in health, new admissions and any appointments people were required to attend. Staff told us this was a useful process enabling them to have all the information they needed in order to provide the most appropriate care and support required. People were supported by staff who knew their health needs and ensured that all members of staff responsible for their care were aware of any changes in the physical or mental wellbeing.

People were encouraged to give their views and raise any concerns or complaints. People and relatives were confident they could speak to staff or the manager to address any concerns. One person told us, "Complaints are dealt with by the manager who is willing to listen, I did have to complaint once and they sorted it out fine." A relative said, "I have not had to raise a concern or make a complaint, but I would be happy to do so, I think the staff are approachable and would listen." Another relative said, "If I have any worries they're deal with straight away, I raised a concern, a cleaning problem early on with the carpet but they've put a hard floor down for him (family member)."

Complaints made in writing and verbally received were documented and recorded in a complaints folder in the manager's office. Two formal complaints had been made since February 2016. Records showed that on each occasion the complaint was investigated fully. The complainants then received full responses within a matter of a few days of making their original complaint. When responding with the investigative updates of complaints complainants were reminded that if they were unhappy with the findings to the investigation they could escalate their complaint to the local authority if they wished.

Is the service well-led?

Our findings

Relatives we spoke with were confident in the registered manager's ability to manage the service and address concerns. One relative told us, "I can't fault it (management and leadership of the service)... she (registered manager) is about all the time". Another relative said, "(the registered manager) Is a good manager and the other two (deputy managers) are great it's great, it really is, they seem to work well and (deputy manager) every night he stays behind and he doesn't go home until he's seen the night crew". People and relatives told us they were happy with the quality of the care provided, one relative said, "You only have to walk in the door here to know it is quality". Another relative told us, "My two girls will tell anyone how good this home is".

The provider completed a number of quality assurance audits at the home to monitor the quality of the service provided. Audits were required to be completed on a regular basis and included auditing the home's infection control procedures; medication, care plans and daily managers 'Walk the Floor' reports. These daily registered manager walk the floor reports looked at a number of areas and included assessing whether or not staffing levels were adequate, if the environment met people's needs and whether or not activities were being encouraged. However we could not see that these daily audits were always being completed on a regular basis in accordance with the provider's guidance. In August and September 2016 we identified that on 19 occasions these had not been completed. However where actions had been identified as requiring additional work these had been completed. For example a Walk the Floor report on 20 September 2016 identified that staff supervisions required completing, we could see that by the 25 September 2016 action had been taken and all staff supervisions had been documented accordingly.

The provider also completed tri monthly audits completed by external senior managers. These gathered evidence of compliance with the Health and Safety 2008 (Regulated Activities) 2014 from a range of sources which included auditing of documentation and speaking with staff and people receiving the service. Where shortfalls were identified during these tri monthly audits actions were created and their completion monitored by the registered manager. During a bi monthly review in March 2016 it was identified that care plans required reviewing to ensure that duplicated information was removed. This made it easier for staff to immediately see the care which was required. By May 2016 we could see that this action had been taken and the care plans updated accordingly. When used effectively quality assurance processes provided the registered manager with the opportunity to improve the quality of the service provided.

The provider's values were openly displayed in the foyer to the home and identified to people, relatives and visitors the type and quality of care people should expect to receive when living at Willow Court. These included the following key areas; placing emphasis that staff would provide high quality care by striving to provide a welcoming atmosphere at the home, the service being open and honest, allowing people to provide feedback and accepting accountability for the services they provided.

The registered manager and staff were not always able to immediately identify the provider's visions and values for the service. However the registered manager wanted to promote an open and person centred culture where people were treated as individuals and as if they were living and receiving care in their own

home. This aim was underpinned by providing a homely environment which had been assisted by the recent redecoration of the service. All staff were able to describe how they felt care should be delivered in accordance with the registered manager's values. This included providing care with dignity and respect, placing the person and their preferences at the centre of all action taken to support them. The registered manager's values were reinforced through supervisions, appraisals and team meetings. This culture was known, felt and appreciated by relatives. One relative told us, "it's a very friendly place to be which considering the constant movement of people is quite hard to sustain but there's a culture, a real strong culture of friendliness and cooperation". Another relative said, " I like coming, it's very friendly and ever since the first day when you walk down the corridors no one who's employed here will walk past you without saying something, they always say something, hello even on the first day and smiles and that says where the culture is very distinctive". Another relative confirmed, "It's a home, it isn't a hospital, it's a home"

The registered manager and deputy managers promoted an 'open door' policy and all were available to people and staff whenever required. Staff told us that they were open with each other and felt subject to valued support from managerial staff. One member of staff told us, "If you have got a problem you can always talk to the managers, they're always open to listen to us anytime". People and relatives told us communication with the registered manager and deputy managers was open and they were available at any time. One relative told us, "The registered manager is seen and will stop and chat with you if she is not too busy. There is good communication with the family, if I'm not coming in and there is a problem they will phone and let me know but if am coming they will tell me when I arrive and that suits me and the family fine".

The registered manager was able to evidence that they knew what was required of their role. Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. We use this information to monitor the service to ensure they respond appropriately to keep people safe. The registered manager had submitted notifications to the CQC in an appropriate and timely manner in line with CQC guidance.

The quality of the service people experienced was monitored through regular care plan reviews and resident and relatives meetings. People were also provided access to 'Tell us what you think' leaflets. These are leaflets which people could leave their feedback, positive or negative anonymously if they preferred. We attended a residents meeting during the inspection where people were asked to provide their feedback on a number of activities which had been held recently to see if they wished these to be repeated. It also addressed a concern which had been raised with activities staff regarding one particular externally provided activity and whether or not people felt it met their needs. As a result of the concerns raised the registered manager had taken action to speak to alternative providers of that activity so that people received the support they wanted. Residents and relatives meetings were held approximately four to six weeks with one held in the morning one month and the following month in the afternoon to ensure those who wanted to were able to attend at a time that suited them. The provider actively sought feedback from people and saw this as a way to improve the quality of the service provided.

Staff identified what they felt was high quality care and knew the importance of their role to deliver this. Staff were motivated to treat people as individuals and deliver care in the way people requested and required. We saw interactions between the registered manager, all staff and people were friendly and informal. People and relatives spoke positively about the care they and their family members received.

A selection of compliments were displayed in the foyer to the home which evidenced the quality of the care being provided. One relative had written 'Like to thank all who were involved in the excellent care provided to my father in the last 4 – 5 years of his life...I shall miss my regular visits to Willow Court and the

relationships I developed with nurses and carer'. Another relative had written 'Mum was really happy to be amongst such lovely people, you all made her smile and knowing how much each of you cared...it has been a pleasure getting to know you...the team here at Willow Court are truly wonderful.'. Another thank you card read, 'I'd like to take this opportunity on behalf of my mum to thank all the staff at Willow Court for the amazing care she was given...when I was able to witness myself the care and dedication given to my mum, for that I will always be grateful'. People were assisted by staff who were able to recognise the traits of good quality care and ensured these were followed.

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	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	<p>The provider did not have an effective system in place to monitor and assess the quality of the service provided taking action where necessary to address and rectify any shortfalls.</p> <p>This was a breach of Regulation 17 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) 2014.</p>