Willow Tree Homecare Ltd

Willow Tree (Romsey)

Inspection report

3 Love lane
Romsey
Hampshire
SO51 8DE
Tel: 01794 523294

Date of inspection visit: 30 November, 2 and 4 December 2015.
Date of publication: 12/01/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection was announced and took place over three days, on 30 November, 2 and 4 December 2015. We inspected at this time because we had received a number of concerns about the care provided. We gave the provider 48 hours' notice to give them time to become available for the inspection.

The service did not have a registered manager. 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. The commission had not received an application in respect of a registered manager.

At the time of our inspection Willow tree provided 281 hours of care in Totton, 335 hours of care in Southampton and 880 hours of care in New Milton. We found the provider had widespread shortfalls in the number of suitably skilled, qualified and experienced staff to meet people's needs. There were a significant number of

Summary of findings

missed care calls which put people at risk of not receiving the care and support they needed. People were often not being supported to take their medicines and not being supported with personal care.

People were not always treated with dignity. People and relatives told us office staff often failed to return their calls and said some staff were not always respectful during care visits.

People were not always supported to take their medicines safely. Staff, relatives and people told us documentation for the recording of medicines administered were not always in place. Staff were not always trained to administer medicines.

Learning and development opportunities for staff were not always provided and placed people at high risk of receiving inappropriate and unsafe care. Records showed significant gaps in staff training. Relatives, healthcare professionals and people told us they were not confident staff had the skills and knowledge to deliver effective care.

Staff were inadequately supported and supervised. Supervision, appraisal, competency assessments and spot checks were not consistently conducted. Staff told us they had not had supervision and on occasions told us they were unsure if they were performing effectively due to the lack of support and direction.

Decisions made in people's best interests were not assessed in line with the requirements of The Mental Capacity Act 2005. Assessments were not related to specific decisions and did not take account of possible risks, benefits, other options and possible consequences.

People who were at risk of malnutrition and dehydration were not always supported effectively. Staff told us the high number of missed calls resulted in some people going without food and drinks at the times they needed it. Nutritional care plans were not always detailed and assessments that were in place were not reviewed frequently.

People's care records were not always personalised and did not always reflect their actual needs and preferences. Staff told us records were not accurate due to the lack of reviews in people's care.

Staff, people and relatives told us they were confident in the new management and felt the direction needed to make improvements was clearer.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The provider had significant shortfalls in respect of the number of suitably qualified, skilled and experienced staff.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely. Risks relating to the health, safety and welfare of people had not been properly assessed and responded to.

Is the service effective?

Inadequate

The service was not effective. Staff were not adequately trained or supported to deliver effective care. We identified significant and widespread shortfalls in respect staff learning and development.

Decisions made in people's best interest were not assessed in line with the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

People were not always treated with dignity and some staff were not respectful when they provided care.

Some records contained detail about people's life histories, personal preferences, hobbies and interests. The majority of people felt staff were caring and compassionate.

Is the service responsive?

Requires improvement

People's care records did always accurately reflect the support they needed and staff often told us the detail was out of date.

Referrals to healthcare professionals were not always made when people required healthcare support.

Some complaints had been investigated and responded to appropriately whilst verbal complaints made by telephone had not been recorded and dealt with.

Is the service well-led?

Requires improvement

The service did not have a registered manager and no new registered manager application form had been submitted by the provider.

The provider had conducted recent audits which highlighted where the service needed to make improvements. These included the areas we found to be not meeting essential standards.

Staff, relatives and people felt Willow Tree was being well led by the introduction of the regional manager but said the service needed a lot of improvement.

Willow Tree (Romsey)

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 is 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 30 November, 2 and 4 December 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is someone who has personal experience of this type of service.

Before our inspection we reviewed previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

During our visit we spoke with the regional manager, an administrator, an electronic calls officer (responsible for monitoring care calls electronically), 12 care workers, 17 people, 11 relatives and three healthcare professionals and representatives from the local authority.

We pathway tracked eight people using the service. This is when we follow a person's experience through the service and get their views on the care they received. This allows us to capture information about a sample of people receiving care or treatment and looked at a further 10 people's care records. We looked at staff duty rosters, eight staff recruitment files, medication records, team meeting minutes, staff training records, supervision and appraisal records, staff induction programmes, safeguarding alerts, complaints and quality assurance documents.

We last inspected the home on 13 and 17 March 2014 where no concerns were identified.

Inadequate

Is the service safe?

Our findings

We received information of concern from healthcare professionals, relatives, people using the service and whistle-blowers. They told us people were not being supported to manage their medicine safely and said the provider did not have good systems in place to assess the risks associated with people's care needs. We were advised there were not enough suitably qualified, skilled and experienced staff employed.

The provider's website states: "The client will receive at all times a flexible, consistent and reliable care service". This statement did not reflect the care experience for many people using Willow Tree's services. The provider had significant shortfalls in respect of the number of suitably qualified, skilled and experienced staff. The regional manager told us the service provided 281 hours of care in Totton, 335 hours of care in Southampton and 880 hours of care in New Milton. 18 complaints related to a series of "missed" and "late" calls had been documented between 29 December 2014 and 24 November 2015. A member of staff said: "There are way more complaints about missed calls than that record shows". Another member of staff said: "The system we use to monitor care calls doesn't work, we only know if a care call has been missed if someone makes a complaint or we see it when the staff bring their time sheets in at the end of the week". A missed call record showed 25 different people did not receive care on 30 September 2015. The regional manager said: "I must be honest and tell you I am not confident that this is the full amount of missed calls. I can't depend on the system we have". A member of staff told us they had worked 37.5 hours administration and delivered 35 hours of care in one week. They said: "There is nobody else to do these calls when staff phone in sick" and "Staff are on zero hours contracts so they don't have to do the work. Weekends are a nightmare for being on call because I always get phone calls from staff telling me they can't come in". One person said: "A few times, they haven't turned up, or they're past the right time. Some get on me nerves – too rushed; the service is up and down. This morning, they were late – then a lady and a young girl came, not who I was expecting". A relative said: "They're usually still late at weekends; there's been a lot of sickness."

Missed and late care calls had a substantial impact on people's wellbeing. For example, eight missed care calls resulted in three different people not receiving their medicines at the correct times. An investigation into a number of missed calls concerning one person found: "person was left in dried faeces and (person) had not eaten" and "(person) is on antibiotics and these had not been given". Other missed calls resulted in people not receiving appropriate repositioning and continence care. A member of staff said: "There has been a problem with missed calls and late calls. Saturdays seem the worst. Yesterday, some of my clients told me they didn't get calls while I was on holiday this week. It's not the office's fault, there's a shortage of staff, and the others have to rush round. One lady didn't get her tablets". One person said: "Evenings vary – the times are getting gradually later – used to be 6.00pm – 6.30pm, but now drifted to 8.00pm, which is a bit late, really. Sunday evenings it may be 9.45pm before they come".

There was insufficient numbers of staff to meet people's needs. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk because appropriate arrangements were not in place to handle and administer medicines safely. People and relatives told us medication administration records (MAR) were not always in place and said staff had not consistently signed the MAR chart to show whether medicines had been taken or refused. MAR charts were often not signed by staff and some care workers had not received training in how to administer medicines safely. One member of staff said: "I have had no training in medication and I have to give people their tablets". A record dated 12 June 2015 to 16 June 2015 showed no medicines had been administered to one person who had prescribed medicines. A staff member told us people were often without their medication if a care call was missed. One member of staff said: "If we miss a call they don't get their meds, it's that simple so we must stop taking on so much, it's really upsetting".

There was a lack of systems in place to manage medicines safely. This was a breach of Regulation 12 (2) and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We received mixed feedback about the suitability of some staff who had been employed to provide care. One member of staff said "Willow tree will recruit anyone just to make sure they can cover the calls" and "We have

Inadequate

Is the service safe?

employed some unsuitable staff". Another member of staff said: "The poor staff are not disciplined or dealt with properly because we can't afford to sack them. We have no staff as it is" and "Even those who let us down regularly – it's difficult to let them go while we're so short of carers". The provider's recruitment process included the completion of an application form, an interview with competency based questions, checks on previous employment and reference requests. Staff were required to undergo a Disclosure and Barring Service (DBS) check. DBS enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with vulnerable adults.

Inadequate

Is the service effective?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us staff were not being inducted into their role effectively and said learning and development opportunities were not provided.

The provider's website states: "The quality of our staff training and development programme means that our staff are knowledgeable, experienced and comfortable in meeting the varying needs of our service users, sensitively and professionally", "Our staff are also fully supervised and monitored and appraised annually, to ensure that they deliver the best possible care support to you" and "Expect to be cared for by staff who have the skills to do their jobs properly". The provider's 'managing staff policy and procedures', dated September 2015, stated: "Employees must receive whatever supervision and support is necessary to enable them to carry out their work effectively".

Staff were not adequately trained or supported to deliver effective care. We identified significant and widespread shortfalls in respect staff development and supervision. The provider's 'managing staff policy and procedures' stated, "both supervision and appraisal are integral to staff support and development; all employees at all levels are therefore required to take part in supervision and appraisal". Supervision and appraisals are important tools which help to ensure staff' receive the guidance required to develop their skills and understand their role and responsibilities. One member of staff had not received an appraisal for a period of four years whilst another member of staff had not had any supervision since they joined in April 2011. A member of staff said: "I came into the job six years ago and I can count on one hand the numbers of times I have had a spot check, an appraisal or a meeting at the office" and "things have got more hectic since the two offices merged into one, the office staff don't have time to do supervisions".

Staff did not have a documented learning and development programme in place and some had not received essential training required to meet people's individual needs, such as dementia, support with their medication, tissue viability care and infection control awareness. The provider's website states: "All our new care workers attend full induction training before they start working independently with our service users and this includes time being trained on site by a senior care worker". One member of staff laughed and said: "You've got to be joking, nobody has a learning programme in place, and we are all far too busy for that". Another member of staff told us they had not received any training since joining the agency. They said: "I am going to be honest here and tell you I don't even have a staff file. In the time I have worked here I have not had any training". The member of staff concerned told us they regularly provided personal care to people which included moving and handling, administering medicines and repositioning care. The regional manager said: "I know we are not where we need to be, I have other services which have been rated good and we are far from that at Willow Tree". Records showed training in safeguarding; Mental Capacity Act 2005, medication, first aid and pressure ulcer care was out of date for many staff. One person said: "The service is not too bad. Some [carers] are all right; some don't know what they're doing – they are very young. I don't think they've had all the training." Comments from staff included: "I'd like to shadow on some double calls to get the practice; I've requested it lots of time, but I haven't had a response yet." And "There are things I don't know how to do but I am not given the chance to learn about it".

There was a lack of training and development for care workers. This was a breach Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider did not act in accordance with the requirements 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. Staff were not always knowledgeable about the MCA and documentation did not show people's decisions to receive care were respected and agreed in their best interest. The providers' capacity assessments were generic and did not show the risks of particular decisions, benefits and alternative options had been considered. Documentation showed consent to provide care was authorised by the representation of a tick in their "service user agreement". Many people had key safes to

Inadequate

Is the service effective?

allow care staff access to their homes; however, no documentation was in place to demonstrate these decisions had been properly assessed. A member of staff said "They should be using the Hampshire tool kit to support decision making". The Hampshire tool kit is a document used for an assessment of capabilities and best interest decision making. Another member of staff said: "If someone has dementia and they can't make a decision about their key safe how do we know they are happy for us to just come in their home?"

People'consent to care was not being sought. This was a breach of Regulation 11(1)(2) and (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service caring?

Our findings

We received information of concern from healthcare professionals, relatives, people and whistle-blowers. They told us people's privacy and dignity was not always being respected. We were told some staff were often unhelpful, rude and did not always respond to enquiries.

The provider's website states: "We know that each person has individual requirements and that providing choice – and respecting our service user's dignity and decisions – is central to their continued well-being and independence".

People's dignity was not always maintained. Despite several conversations with staff, discussions with the care coordinator and formal complaints made, one person continued to receive care from a member of staff who was not suitable or physically capable of delivering the care they needed. The relative said: "It's about my mum's dignity, she is meant to have two to one support to help her move and have personal care but because there is often not enough staff she only gets one person and they can't move mum properly" and "it's embarrassing for mum". A member of staff told us it was not always possible to match staff against people's individual needs and preferences. They said: "Because we are short staffed it is just not possible sometimes. We can offer care but if it is not what they want then we struggle to accommodate them".

People's calls were not always returned when they had queries about their care. A member of staff said: "Well, my clients tell me if they ring and ask for a call-back, it doesn't happen. I phoned (staff member) who was in a meeting, and she didn't call me back. It's all a bit erratic". A relative told us they often have to call the office to find out who is coming to deliver care. They said: "We need to know otherwise we are in limbo just sitting here waiting. It wouldn't be so bad if they actually called back so we knew what was going on and who was coming".

People were not always treated with dignity and respect. This was a breach Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of people and relatives we spoke with told us staff were caring and tried their best to meet people's needs. One person said: " A lady [member of staff] was so kind – she brought me a video to watch – it was called 'The Rocky Horror' – I'd never seen the show, as the seats were all booked up, so she brought the video from home and set it up for me!" When asked if one person felt safe and if their dignity was respected they said: "Oh yes, I am safe, and my dignity is respected – I am 91, and there's nothing I'd change, although some of them are in a hurry –but usually it's OK". The regional manager told us many of the staff were caring and but recognised a small number of people had been employed who did not have good values and were often unreliable. A member of staff said: "I'd say 95% of the carers are brilliant; 5% are not. Some will let you down at the last minute, and some are always willing". One person said: "On the whole they're a good crowd".

Requires improvement

Is the service responsive?

Our findings

Care plans did not always provide sufficient detail and guidance for staff to provide care. Information about nutrition and hydration; skin breakdown; continence care; showering and shaving was not always included. A care plan for one person who required continence care and assistance to shower did not provide guidance about how staff should assist them to meet their needs. Staff often told us they were confused about the care they needed to provide due to insufficient care planning and poor communication. Staff consistently told us risk assessments and care plans did not always contain good detail and were not always accurate. We observed seven new care workers taking part in their induction programme. When speaking about risk we heard one new member of staff say: "We can look in their (people's) risk assessments and they will tell us what the dangers are and how to help". Another new member of staff said: "The risk assessments will tell us what we need to do and how serious something is". The risk assessment and care plan for one person who required support with their Percutaneous endoscopic gastrostomy (PEG) did not provide sufficient detail to keep the person safe and free from possible infection. A PEG provides a means of feeding when oral intake is not possible. An assessment for another person who had been identified as "high" risk of tissue damage did not contain guidance for staff to support them with their skin integrity. On the second day of our inspection the regional manager told us they had looked at the risk assessments concerned and said: "I see what you mean, there should be a lot more detail than that. I am really disappointed".

Strategies for people who had limited mobility and were at risk of falls. One persons "falls/mobilising risk assessment" dated 17 June 2015 stated a risk rating of "18" which according to the providers criteria for assessing severity of concern meant they were at high risk of falls. Their care plan said staff were required to reposition the person and document they had done so in their daily record. A member of staff told us two care workers were needed for this particular care visit. They explained the person received four care calls each day and said: "This person's call is really important because they have high needs and they depend on us for food, drinks, personal care and to change their pad". Records did not show staff had always recorded the repositioning care as required. Strategies to reduce the possibility of skin damage were not robust and unclear. A member of staff told us there were occasions when only one care worker attended the call due to insufficient staffing numbers.

People who were living with dementia did not have best practice guidance in their care plans and information about behaviours that may have challenge others were not recorded. One member of staff said: "Sometimes (person) says things I don't understand and (person) can become pretty aggressive". Another member of staff said: "The care plans at the houses are pretty poor, they don't have much in them that tell you how to deal with difficult behaviour and to be honest, I am not that confident anyway". Staff told us care records in people's homes were out of date, not accurate and unused. For example, a member of staff explained the care needs of one person who required personal care and support to be repositioned. They said: "If a new member of staff came out here to help unless I told them what to do they wouldn't have a clue and that's not fair on (person)".

People's nutritional needs were not always being met and referrals to healthcare professionals were not always being made. A nutritional care plan dated 17 June 2015 stated: "(person) finds it difficult to swallow" and the risk assessment stated "high" risk of choking. The risk assessment and the care plan did not instruct staff how to meet the person's nutritional needs safely. The assessment stated there was no need to refer the person to be assessed by the speech and language team. Records did not show staff recorded food and fluid intake despite it being a requirement in the care plan. Training records showed some staff who provided care to this person had either not had appropriate training in nutrition and hydration or they required an update in their learning. Relatives told us their family members had gone without eating and drinking on occasions due to missed calls.

This was a breach Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We received mixed feedback regarding the provider's ability to respond to complaints. The provider had a system in place for recording and investigating complaints. However a member of staff told us complaints received in writing were generally investigated but those made by telephone were not always recorded and dealt with properly. They said: "We don't record every compliant and unfortunately we don't have the time to investigate everything because

Requires improvement

Is the service responsive?

we are so busy trying to cover calls". A relative told us they complained four times over the telephone about the high number of missed and late calls and said: "I was not happy with the responses I got because nothing really changed". Another relative said: "I have contacted the local authority and CQC because they have done nothing about my complaint".

There was no system to ensure that risks were assessed and acted upon to ensure people were protected. This was a breach of Regulation 16 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities (Regulations 2014)

Records documented people's interests, histories, wishes and personal preferences. For example, one person's care plan documented their musical interests and activities they enjoyed whilst another record for a different person documented their accommodation history and wishes for the future. Staff were knowledgeable about the people they cared for. A member of staff said: "I have worked with (person) for a long time now, I know she likes music, dancing and she used to be a teacher. She was married and she has grandchildren who visit her".

Requires improvement

Is the service well-led?

Our findings

The service had been without a registered manager since 15 October 2015. Willow Tree was being managed by a regional manager who told us they would continue to work from the location until a new registered manager had been appointed. The provider had not submitted an application for a new registered manager. Until services have a registered manager application accepted by the Care Quality Commission (CQC) we are only able to judge that the leadership of the service requires improvement. However, people and staff spoke positively about the regional manager and their leadership. One member of staff said: "She (regional manager) has been brilliant, she is really approachable and she works really hard. I feel for her because I don't think this mess we are in is her fault".

The regional manager told us Willow tree was "struggling" to meet some people's needs due to high number of staff sickness and insufficient staffing numbers. They said: "We know we have staffing problems, some are brilliant and some don't have the right attitude". They told us Willow tree had informed the local authority they were unable to accept any further admissions. They said: "We have put a voluntary stop on admissions" and "The biggest challenge we have is staff retention is not good". One person said: "The new manager (regional manager) has been a breath of fresh air and I am really encouraged by what she has done so far". People spoke positively about the regional manager and felt they could speak with her if needed.

Since the contribution and on site presence of the regional manager staff have told us the service is beginning to move in the right direction. A member of staff said: "We have such a long way to go and we are all still really stressed about everything but I think it will get better". Records showed a small number of staff had started to receive formal office based supervision and spot checks. The provider had recruited a new trainer who was experienced and competent. We observed some aspects of the training being delivered and found it to be informative and robust. Topics in the staff induction included safeguarding, person centred care and dementia. Other records viewed showed some staff had received training in how to asses and document risk, complete care plans and recognise signs of dehydration and malnutrition. The regional said: "We are not a good service yet" and expressed her disappointment in how the care people received had declined. They said: "I believe we will get there".

Recent records showed the provider had started to audit some aspects of people's care plans and risk assessments. Some staff team meetings had taken place and learning workbooks had been allocated for staff to complete to support their learning. A member of staff told us the development of staff was difficult because the priority was ensuring people received their care calls. Another member of staff said: "There is a lot of work to get right in terms of staff training and supervisions but I think it will start to get better. We have trust in the new management and once we start dealing with the staffing problem it will get much better". Another member of staff said: "We need to make sure we don't keep taking on more and more care packages otherwise the service will go bust. We need time to get things sorted out first then we can take more. Surely it's about giving quality care".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not have a sufficient number of qualified, competent, skilled and experienced staff deployed. Staff did not receive appropriate support, training, professional development, supervision and appraisal.**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not appropriately assess the health and safety of people and did not take reasonable steps to mitigate risks. Staff were not appropriately qualified to meet people's needs.**

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider did not act in accordance with the Mental Capacity Act 2005.**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **People were not always treated with dignity and respect.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The provider did not have effective systems in place for identifying, receiving and handling complaints.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have a sufficient number of qualified, competent, skilled and experienced staff deployed. Staff did not receive appropriate support, training, professional development, supervision and appraisal.

The enforcement action we took:
We have issued a warning notice in relation to this regulation.