# The Willows Residential Care Home Limited

# The Willows

## Inspection report

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09 March 2021

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Willows provides accommodation with personal care for up to 32 older people, including people living with dementia. It does not provide nursing care. Accommodation is provided in one adapted building. During the first day of our inspection visits, 22 people lived at the home and one person was in hospital. On the second day of our visits, 20 people lived at the home.

People's experience of using this service and what we found
People did not receive safe care. Staff had not completed all the training they needed to provide safe care and their competency had not been assessed following training to confirm their learning. People's care plans did not always contain accurate information to help staff support people safely.

Risks associated with people's care were not promptly identified and managed. Infection prevention and control was not safe. Medicines were not always managed safely in line with best practice guidance to ensure people's healthcare needs were managed effectively.

Governance systems, and management and provider oversight of the service, were inadequate. Systems and processes designed to identify areas of improvement continued to be ineffective. Systems to identify and manage potential abuse were not effective. The providers policies and procedures did not always provide staff with the guidance they needed. Audits and checks had not identified the concerns we found. This demonstrated lessons had not been learnt since our last inspection.

The management of individual and environmental risks continued to require improvement.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was Requires Improvement (published 25 February 2020) and there were two breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made and the provider continued to be in breach of the regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 21 January 2020 where breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do, and by when, to improve safe care and treatment, and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We also had received complaints and concerns prior to our inspection visit in relation to the management of risks at the home and how people's needs were met. As a result, we

undertook a focused inspection to review the key questions of Safe and Well Led only.

This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions that were not looked at on this occasion, were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Willows on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We identified breaches in relation to risks associated with people's care and management oversight of the service. The provider had not ensured effective systems and processes were in place to monitor the quality and safety of the service and drive improvement.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service was not safe. | **Inadequate** |
| **Is the service well-led?**<br>The service was not well led. | **Inadequate** |

# The Willows

**Detailed findings**

## Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This focussed inspection was carried out by five inspectors. On 16 February 2021, three inspectors visited the home. Another inspector gathered and reviewed information from the manager via email and spoke with relatives. One further inspector spoke with staff over the telephone to gather feedback on their experience of working at the service. On 9 March 2021 one inspector returned unannounced to check progress in regards to infection control risks identified on 16 February 2021.

Service and service type
The Willows is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The previous manager deregistered on 1 April 2020. The provider had recruited a manager who had been in post for several weeks at the time of our inspection visit. At the time of our inspection a registration application had not been made for them to become registered with CQC.

Notice of inspection
We gave the service 90 minutes notice of our first inspection visit because the service was inspected during

the coronavirus pandemic, and we wanted to be sure we were informed of and followed the provider's coronavirus risk assessment for visiting professionals, before we entered the building. The second day of our visit was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We observed three people who used the communal areas of the home to understand their experience of living at the home. We spoke with four relatives about their experience of the service. We spoke with 18 members of staff including night care staff, the manager, and deputy manager.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at staff recruitment arrangements and viewed a variety of records relating to the management of the service. This included the providers policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training information and spoke with visiting professionals who regularly visit the service.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Information we received prior to our visit indicated people did not always receive safe care because some risks associated with their safety were not managed well. We found this to be the case during our inspection.

● One person had lost 10kg in weight between May to September 2020. The person's care plan dated 1 October 2020 indicated the person should be weighed and have their nutritional risks reviewed monthly. This had not happened for four months. Weighing scales used at the home were in need of repair to enable regular weight monitoring to take place. Staff told us several people had lost weight. This lack of oversight and monitoring of weight put people at increased risk of malnutrition.
● Care records were not accurate to support people's needs and manage risk effectively. For example, in one section of a person's care plan it stated they needed support of one staff member to assist with moving and personal care, but in another, it said the person needed two care staff for all aspects of personal care. There was a risk the person may not be supported to move and receive care safely.
● People at risk of skin damage did not have clear records to show how this risk was managed. One person needed to be repositioned every two hours when they were in bed to prevent skin damage. Records checked over a seven-day period showed on four days the person was not repositioned. The person had developed skin damage that would have required regular attention and repositioning. The lack of repositioning can significantly increase the risk further skin damage.
● Staff were not always aware of people's needs or how to provide safe care. For example, one person's care plan stated they were at risk of choking and needed to be sat up in bed when eating to reduce this risk. Records did not confirm this happened. A staff member told us, "One day they were coughing, and I did not know what to do …They (staff) have not told me anything about choking – when I help them to eat and drink, [person] goes red in the face when they cough, and it scares me. They really should be sat up." This demonstrated the instructions to help prevent the person from choking were not followed. This person's care has subsequently been reviewed to mitigate this risk.
● The provider's contingency planning for use in the event of an emergency was inadequate. Fire door and fire exit testing logs did not show which doors had been checked. During our inspection visit we identified one fire door which was not operating safely.

● Staff were unclear about what fire procedure they needed to follow to keep people safe. One told us, "I have no idea how to get people out really, just try to get them outside if we can."
● The provider has subsequently advised of actions to address fire risks. Fire risks were also reported to the local fire service by CQC to enable these to be monitored and managed accordingly.
● Risks associated with people's care were shared with the Local Authority by CQC to enable these to be assessed and acted upon as required.

Systems and processes to safeguard people from the risk of abuse
● Where there had been serious incidents within the home, these had not been reported to the CQC, and in some cases, the local authority as required, to help ensure risks had been managed to keep people safe.
● Staff did not understand their responsibility to safeguard people from harm by reporting poor practice by other staff. For example, we saw poor infection control practices by some staff was not challenged by their colleagues.

Using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Processes to support safe medicines practice needed to be improved.
● One person was prescribed a medicine that needed to be given 30 to 60 minutes before food to ensure this was effective. There were no arrangements in place to ensure these important administration instructions were followed. A staff member told us the person was given their medicine with their breakfast which confirmed prescribing instructions were not followed and the medicine may not be effective.
● One person's medicines were administered 'covertly', that means hidden in their food or drink. The person's care plan for giving medicines covertly had not been reviewed for 14 months. Good practice, and the provider's procedure, required that the decision to give the medicine covertly should be reviewed at least every six months. This is because people's capacity to make decisions can fluctuate and if this happens, it may no longer be appropriate, to administer their medicines covertly.
● Some people required medicines at night time and although medicines had been administered, staff who worked at night had not been trained or deemed competent to give those people their medicines. Our conversations with night staff confirmed there were no consistent or clear processes in place to address safe medicine administration at night to ensure people received their medicines safely when they needed them.
● Prior to, and during our first inspection visit, we were informed that one person's pain was not always managed effectively. The person had been prescribed paracetamol to manage their pain four times a day. However, on 13 days during February 2021 the person had only received their medicine twice a day. A staff member told us, "To me, it looks like [Name] is in pain by the look on their face, they have paracetamol, but I am not sure this is enough for them, even if they are given it."
● One person was prescribed medicine 'as required' to manage their levels of anxiety. Guidance was not available to inform staff when they should give the medicine. Staff had not recorded why it had been given to enable any triggers to the person's anxiety to be identified and ensure this was managed effectively. There was a risk the person may receive sedation when this was not necessary.

Preventing and controlling infection

● The providers systems and processes in place to manage infection outbreaks and protect people from the risk of infection were inadequate.
● People who had tested positive for COVID-19 used communal toilets which were not cleaned between use. This posed a significant risk of infection spreading. Immediate action taken by the manager prompted by CQC during our first inspection visit to mitigate this risk, was not effective.
● The provider was not complying with shielding and social distancing rules. Staff were not co-horted in line with government guidance which posed a significant risk. Staff provided care to people who had tested positive and negative for COVID-19 which was unsafe.
● Staff had not completed sufficient infection control training. On the first day of our visit staff, including the manager, wore their masks beneath their noses and often underneath their chins. They touched their masks without sanitising their hands or changing their mask. On the follow up second day of our inspection, a staff member wore a mask that did not meet with recommendations. This poor infection prevention practice increased the risk of infection spreading.
● Laundry processes were not safe and did not minimise the risk of cross infection. Washing baskets containing dirty laundry did not have lids, other baskets were open weave. Red bags containing soiled laundry were located next to clean linen on the floor.
● The provider did not prevent visitors from catching and spreading infections. Visitors were not screened for symptoms of COVID-19 in line with current guidance or the providers procedure when they arrived at the home.
● Following our inspection visit, the provider acted to ensure infection prevention and control within the home was improved.

We found evidence that people were at risk of being harmed and systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider was unable to demonstrate that staff on duty had the skills, knowledge and experience to meet people's needs and provide safe care. Staff demonstrated considerable gaps in their knowledge in respect of risk management, infection control, safe medicines management and fire safety.
● Checks to ensure agency staff were suitable to work at the home were not sufficient. There were two agency staff on duty on the afternoon of our first inspection visit. The manager did not have sufficient information about either member of agency staff on duty to determine their suitability to work safely with people. This included no form of identification. One of the agency staff on duty had never worked in the home before
● In response to the immediate risks presented by COVID-19 that we identified during our first inspection visit, the manager introduced an hourly bathroom cleaning checklist and welfare checks of one person every twenty minutes. Staff did not complete these checks within the timescales set by the manager.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two of the three relatives spoken with felt their family member was safe at the home. They spoke positively of the permanent staff employed at the home. Comments included, "The girls (staff) are kind and good. I'm happy about [Name's] care," and "The girls laugh and joke, they are so nice…they try to make it happy."

Learning lessons when things go wrong
● Actions taken following the last inspection showed insufficient action had been taken to improve

demonstrating lessons had not been learnt.

● An Infection Prevention Control assessment completed by the local Clinical Commissioning Group in December 2020 highlighted numerous areas needing improvement. These areas had not been sufficiently addressed.

● The lack of management oversight meant areas needing improvement were not identified to ensure lessons could be learnt.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the providers quality monitoring systems and processes were not effective and did not support continuous improvement. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Information we received prior to our inspection visit indicated the service was not consistently well-led. We found this to be the case. The provider had failed to maintain sufficient and accurate oversight of the service resulting in poor outcomes for people. Regulations had not been met and lessons had not been learnt to improve care.
● Risks associated with people's care were not always managed well and governance systems to monitor the quality and safety of the service, were inadequate. For example, some people were at risk of not eating and drinking enough and their food and fluid intake was to be monitored. Records had not been regularly or accurately maintained to show people had received sufficient, suitable food and drinks. A staff member told us, "Nobody really checks them" (referring to the records). There were people who had lost weight.
● Medication audits had not identified the risks related to the management of medicines we found. This included incorrect codes being used on medicine administration records which made it unclear whether people had received them. There was unsafe storage of medicines; for example, topical creams were stored in a bathroom and medicines to be returned to the pharmacy were stored on the floor in an unlocked office. People living with dementia could have accessed and swallowed these medicines.
● The manager had held staff meetings to discuss areas of improvement needed. However, checks to ensure instructions given to staff were followed did not take place.
● The provider's systems to safeguard people were inadequate. An effective system to confirm the identity of agency staff and ensure they had the appropriate training and employment checks in place to provide safe care was not in place.
● The provider demonstrated limited commitment to improving standards and meeting their regulatory responsibilities through lack of actions. An infection prevention and control audit completed by the local Clinical Commissioning Group in December 2020 identified significant infection control concerns. Some concerns had required immediate remedial action, but very limited action had been taken in response to

the findings. We identified significant infection control issues at this inspection.

This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Relatives told us they had some contact with staff at the home regarding their family member's needs. One told us, "[Staff name] went through the care plan with me when [Name] moved in. They do inform me if [Name] is not well and if I phone, they let me know if the doctor has been….The hairdresser is not allowed in, so they have done [Name's] hair."

● Staff did not follow good infection control practice and the manager did not always model good practice and lead by example. On numerous occasions we saw the manager did not use Personal Protective Equipment (PPE) correctly to manage the risk of infections spreading. This placed people at risk.

● Staff gave mixed views about the management team being supportive and didn't feel when issues were raised, they were always listened to. One staff member told us, "I have tried to talk with the managers, and they do nothing." Another said, "I don't feel valued at all working here."

● Staff told us they wanted to provide safe, person centred care but they didn't always feel supported by the manager. They did not have opportunities to complete training they needed or have time to read care plans to be able to do this. One staff member said, "It's a massive home and hard to learn things and getting to know people is hard here really." Another told us, "The staff they employ now, they just don't get the training and don't care or have the skills they need." Staff training records demonstrated gaps in training.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

● The provider understood the need to be open and honest when things went wrong. However, when issues had been shared with them, sufficient action had not always been taken to make the required improvements.

● The provider had failed to ensure their legal responsibilities to report serious incidents in the home to CQC was followed consistently, to protect people from potential abuse or harm.

● There has been no registered manager at this service since April 2020 and at the time of the inspection no approved application had been received by CQC. Following our second visit the provider informed us the manager was no longer working at the home.

● The provider worked with the health and social care professionals involved in people's care so they could support people's physical health and wellbeing.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People had limited opportunities to engage with others and members of the public. This had been partly due to COVID-19 restrictions put in place. Most people were being cared for in their bedrooms. On the first day of our inspection, three people used the communal areas.

● Relatives felt communication with them could be improved. One said, "Not seen [Name] for the last year. Won't let us in. Communication has not been good. Don't get me wrong they look after [Name] no problem with care… Have had absolutely no information about when visiting will be resumed." Another told us, "I've been able to do window visits, but I have only had one physical visit since last year."

● Staff attended team meetings with the manager where issues relating to the home were discussed. However, notes of the meetings did not demonstrate staff were involved in discussions or show they were asked to contribute ideas for improvement.

● Staff told us they did not always feel involved in decisions and did not feel listened to. One staff member said, "Nothing is good here. Everything needs to be improved here."

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had not ensured care and treatment was provided in a safe way.<br><br>The provider had not ensured risks associated with people's care, and the environment were identified, assessed and mitigated. This included risks associated with infection prevention and control.<br><br>Regulation 12 (1) (2) |

**The enforcement action we took:**

Conditions imposed on the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Effective systems were not in place to assess, monitor and improve the quality and safety of the service provided.<br><br>The provider had not ensured records relating to the care and treatment of each person using the service were accurate and up to date.<br><br>The provider had not ensured, timely improvements to the service were made, and sustained.<br><br>Regulation 17 (1) |

**The enforcement action we took:**

Conditions imposed on the provider's registration.

| Regulated activity | Regulation |
|---|---|

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed to ensure people received safe care that met their needs effectively.

Regulation 18 (1)

**The enforcement action we took:**

Conditions proposed on the providers registration.