Churchgate Healthcare (Willows) Limited

Willows Care Home

Inspection report

229 London Road
Romford
RM7 9BQ
Tel: 01708765899
Website: www.churchgatehealthcare.o.uk

Date of inspection visit: 9 January 2015
Date of publication: 19/05/2015

Ratings

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

Overall summary

The inspection was unannounced and took place on 9 January 2015 in response to anonymous concerns we received about the care delivered at the service. There had not been any previous inspections since the provider registered with the Care Quality Commission in September 2014.

Willows Care Home is registered to provide accommodation for up to 70 people who require nursing or personal care. It is a modern and purpose built nursing and residential home situated in Romford. On the day of our visit, there were 20 people using the service.

At the time of inspection a registered manager was in place. 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.

Summary of findings

We found that the provider was not meeting some of the legal requirements in relation to medicines management, care and welfare of people, records, staffing levels and nutrition. You can see what action we told the provider to take at the back of the full version of the report.

Medicines were not always managed appropriately, especially for people who self-administered their medicines. There were no risk assessments in place to ensure that the person stored their medicines safely and took their medicines as prescribed.

People were not protected against the risks associated with receiving care that was inappropriate or unsafe. Risk assessments were not always completed or updated.

People's care records were not always accurate and did not always reflect people's current needs. Other records such as food temperature probe checks and daily medicine room temperature checks were not always completed.

People were not always given a choice of food that met their individual needs or preferences. Although individual food preferences were documented these were not always followed.

Staffing levels were monitored according to people's needs. However, there were staff vacancies at the time of our inspection and a lot of agency staff were used to cover shifts. This meant that people were not always supported by staff who knew them and their needs. On the day of our visit three staff working on one floor with six people were all agency staff.

The service followed safer recruitment practices and ensured that there were arrangements in place to deal with foreseeable emergencies. Staff received training and supervision.

Where people lacked the mental capacity to make decisions, the registered manager and nursing staff made best interest decisions in line with the Mental Capacity Act 2005 (MCA). This included making applications for Deprivation of Liberty Safeguarding authorisations (DoLS) where it was felt necessary to impose restrictions on people in their best interests. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a person is deprived of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Staff understood that a person could have capacity to make some decisions but could lack capacity to make more complex decisions.

People's needs were assessed on admission but were not always reviewed or updated in line with policy or when people's needs changed.

Although activities were provided by the home these were not frequent. This left people bored and just sitting in communal areas or in their bedrooms. People told us that they did not always have information about what was happening.

Staff and relatives told us that although they could approach the manager at any time they felt that issues were not always resolved. There were clear leadership structures in place. There was a procedure to monitor the quality of care delivered but it was difficult to monitor effectiveness because the home had only been operating for four months.

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 unsafe. There were inappropriate arrangements in place to ensure that the risks associated with self-administering medicines were minimised.

Staffing arrangements did not meet people's needs or ensure their safety.

The home followed safer recruitment practices and ensured that there were arrangements in place to deal with foreseeable emergencies.

Staff had completed safeguarding training and were aware of how to identify and report any abuse.

Is the service effective?

Requires Improvement

The service was ineffective. People were not always offered food that met their individual needs or preferences.

Where people lacked the mental capacity to make decisions, the manager and nursing staff made best interests decisions in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff had a comprehensive induction and completed training such as infection control and basic life support. Regular supervision was in place to enable staff to reflect on practice and make changes where necessary.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. Staff were not always available to care for people in a timely manner.

People were treated with kindness and compassion. We observed staff treating people with dignity and respect.

Staff were aware of people's individual needs and were able to tell us about their life stories.

Is the service responsive?

Requires Improvement

The service was not always responsive. People's needs were assessed on admission but these assessments were not always reviewed or updated in line with the provider's policy to ensure that people's individual needs were met.

Activities were limited which meant people were bored and were not engaged in social activities that met their individual needs and preferences. People told us that they were not always kept informed about the activities that were taking place.

Complaints were acknowledged, investigated and a written response was issued in line with the provider's policy.

Summary of findings

Is the service well-led?

The service was not always well-led. Staff and relatives told us that although they could approach the registered manager at any time, issues such as team work were still being resolved.

There were clear leadership structures in place. There were systems in place to monitor quality of care delivered. However, team working was not yet embedded and recruitment was still in progress in order to reduce agency staff use.

Requires Improvement

Willows Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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 9 January 2015 and was unannounced. The inspection was completed by one Inspector.

Prior to the inspection we reviewed information we held about the home and asked the local authority and the local Healthwatch if they had any information about the service.

During the inspection we spoke to nine people using the service and eight relatives and friends. We interviewed staff including the registered manager, care staff, the chef, the activities coordinator and the head of maintenance. We conducted a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed interactions between staff and people using the service. We reviewed three people's care records, another four people's medicine administration record charts, four staff files and other records relating to the management of the home.

After our inspection relatives raised concerns with us about the care and management of falls and we reported these to the local authority and reviewed the outcomes of these cases.

Inadequate

Is the service safe?

Our findings

People told us that they liked the home and the staff but said that there did not appear to be enough staff on duty especially during the morning and at night. One person said, "Staff are very good, there just doesn't seem to be enough of them." Another said, "We see a lot of different faces. Some are better than others but I prefer the regular staff".

Risks of potential harm or restrictions put on people using the service were not always assessed to ensure they were managed appropriately. For example, one person had no risk assessment for the restrictive wear we saw in use on the day of the visit. This person had a sock on their hand to prevent them from pulling off a dressing applied on a wound. However, there was no risk assessment to this effect. Although staff told us they had discussed this with relatives we saw no evidence of the agreed management plan in place. There was no evidence that alternative arrangements had been explored to protect this person without imposing undignified restrictions.

Identified risks were not always appropriately managed. For example, we observed that one person was distressed, demanding to go home and found no risk assessment or support plan to manage this behaviour. Staff told us, and we saw in the care records we viewed, that there were no systems in place for monitoring circumstances where people refused care or whose behaviour at times challenged the service. Therefore staff were not provided with sufficient guidance to enable them to manage risks to people's safety.

This was a breach of regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1)and (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing levels were determined according to people's needs, however, we found that the staff skill mix, lack of organisation and the layout of the building did not promote people's safety. For example, we observed that staff were not able to meet people's needs in a timely way during mealtimes as staff were in different areas of the building. One staff member remained in the dining room serving while other staff brought people into the dining room and assisted people to use the toilet. The nurse was preparing to give medicine.

We found that there were not always enough suitably experienced and skilled staff on duty to meet people's needs. For example, there were at least three episodes in December where there were only three staff caring for up to 23 people. This was confirmed by staff, the staff rota, people and relatives. In addition staff records and interviews confirmed that some of the staff either had little experience or came from an agency and therefore were not very familiar with the service or people's needs. Records showed that there was constant flow of new admissions throughout December with three admissions on 24 December 2014. However according to the rotas we reviewed and feedback from relatives and staff, the staff on duty did not always have the skills and experience to ensure that these admissions were managed safely. Further new admissions were anticipated as the service had a contract with a local hospital to provide short term care to people who were waiting to be assessed for continuing care.

People said they had to wait for prolonged periods of time for assistance, especially in the morning. On the day of our visit there was an over reliance on agency staff. For example, on one floor there were six people on respite care, with further planned admissions expected. This floor was staffed by three agency staff, who could not demonstrate to us that they knew the people or the provider's documentation very well. This meant that people were not supported by regular staff who could help them settle into their new home and ensure that their admission assessment was completed properly so that their individual needs were met. Two out of the three staff had worked at least two shifts within the service. The day after the inspection, we received information that two falls had occurred on that floor, one of which had not been managed properly. The manager confirmed that they had at least three nurse vacancies as well as care staff vacancies. There was a recruitment plan in place with scheduled interviews.

This was a breach of regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

People were not always supported to take their medicines safely. The registered manager told us that a risk assessment was completed for people who chose to self-administer their medicines to ensure that this was done safely. However, a risk assessment had not been completed for the one person who self-administered their medicines. This meant that there was no record to show that staff had assessed any potential risks or taken steps to ensure that there were arrangements to ensure that the person took their medicines as prescribed and stored them safely.

We found gaps in the records for fridge temperature checks in the treatment room where medicines were stored. This made it difficult to verify if these checks had taken place and what the outcome was. If medicines were not stored at the correct temperature this could have reduced their potency which could result in people receiving ineffective medicines.

This was a breach of regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they could raise any concerns with the registered manager at any time but were not confident that their concerns would be dealt with appropriately. Staff told us how they would recognise signs of potential abuse and told us they would inform the registered manager who would report to the local authority, the Care Quality Commission and sometimes the police. They told us that they would also document any cases of abuse on an incident form. We saw evidence that staff had received safeguarding training.

There were arrangements in place to deal with foreseeable emergencies. Staff were able to describe the procedure to follow in a fire or medical emergency which included calling for help by pressing the emergency buzzer and calling an ambulance. They were aware of the evacuation procedures and the location of the fire exits.

The home followed safer recruitment practices. We looked at four permanent staff files and found that pre-employment checks had been completed. These included references, identity checks and criminal record checks to ensure that staff were suitable to work with people who used the service.

There were clear staff disciplinary procedures which staff were made aware of when they started to work at the service. The registered manager showed us documentation within a staff file where the provider's disciplinary procedure had been followed. This meant that procedures were followed to ensure that people were cared for by staff who delivered care safely.

Requires Improvement

Is the service effective?

Our findings

Three out of the nine people told us they liked the food whilst the rest said supper and breakfast choices could be improved. People said they would prefer more cooked breakfasts and a hot meal in the evening. They also felt that there was not enough choice. We looked at the menu and found that there was only one dessert on offer. The four week menu cycle offered one main course plus a vegetarian option which was not acceptable for some people. Although there was an option to have a salad or an omelette on the menu people said they had not been made aware of this.

People were not always supported in a timely manner at meal times. During meal times people had to wait. For example, at one point there was one staff serving six people in the dining room. One person had to wait for 10 minutes whilst the staff member supported others to eat and another person had to wait for staff to notice that they were not eating before staff realised that they had not put jam on the person's bread. Once the jam was spread we saw the person finish their breakfast.

Although staff knew which people were on special diets, monthly weights and nutritional risk assessments were not always completed in order to identify risks to people with complex needs in their eating and drinking. This could delay referrals for issues such as weight loss.The above issues related to a breach of regulation 14 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 , which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff did not always respond to people's health needs appropriately and referrals were not always promptly made to healthcare services when people's needs changed. For example, two relatives said that they had insisted on taking their family members to the hospital when they noticed changes in their condition. On both occasions the person was admitted to hospital. Both cases were confirmed and investigated by the local authority.

Staff were supported to attend an induction which included dementia awareness, dignity in care, health and safety, first aid and fire safety awareness. Regular supervision included discussions about how people were progressing and reflection on any incidents that had occurred. This meant that staff were supported to recognise areas for improvement and learn from incidents. Staff files and the training matrix showed that training included infection control, safeguarding, manual handling and administration of medicines.

Where people lacked the mental capacity to make decisions, the registered manager and nursing staff made best interests decisions in line with the Mental Capacity Act 2005 (MCA). Staff had received some training and understood that people could have capacity to make some decisions but could lack capacity in making more complex decisions such as decisions about their finances. Staff told us, and we observed, that they sought people's consent before offering care and treatment. We saw staff talk to people before assisting them to eat or assisting them to transfer from wheelchair to a chair.

We saw that a Deprivation of Liberty Safeguards (DoLS) authorisation had been applied for one person and a best interests assessor was scheduled to come and assess their needs and check if restrictions should be imposed to keep the person safe. Staff were aware that they needed to apply for an authorisation to deprive a person of their liberty and knew that an application should be submitted to the local authority for consideration.

The service had procedures in place to ensure that 'do not attempt resuscitation' orders followed current guidance from the Resuscitation Council (UK). There was evidence that discussions involved the people using the service, their families where appropriate and relevant healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

Most people told us that staff were caring and kind. One person said, "Staff are very good. They treat me well." Another said, "Staff are extremely kind and polite. They have given me good care so far." A third person said, "On the whole staff are good. You can share a joke or two. However, we keep seeing new faces and some are a bit too serious and don't always introduce themselves." A fourth person said, "There are a couple of good staff here. But you always get a few bad ones, especially the agency staff." Two people told us they thought agency staff delivered the care but did not always have the personal touch such as conversing or in depth knowledge of people's needs.

People were treated with kindness and compassion. We observed that people in the lounge were supported by staff who responded to them with care and empathy. However, we noted that at meal times people were not always supported in a timely manner. Some people had to wait to be assisted as staff were busy assisting other people.

We observed staff treating people with dignity and respect. A relative said, "Dad always looks clean when we come. Staff always acknowledge us when we arrive." We saw staff knocking and waiting for a response before entering people's rooms and people were supported with personal care when required. However, this was not always done in a timely manner as there were not always enough staff available to support people.

Staff were aware of people's individual needs and knew about their life stories. They could tell us about people's preferences and described one person who liked their food very hot. Staff said they would microwave the food in the dining room before serving to ensure this preference was met. We observed this being done during lunch.

People were given the information and explanations they needed. One person said, "Staff always answer my questions if I have any queries about my care or hospital appointments." Another said, "They told me before I moved in that I would have to pay for a carer to take me to my hospital appointment. I don't agree with it but at least they told me in advance." We saw one person express their worry about their relative who was in hospital. Staff responded by calling the hospital to check on their progress before offering reassurance to the person.

Staff told us that they did not give out confidential information about people over the phone unless it was a healthcare professional request. They said they would always gain people's consent first. We saw evidence that staff had received training on confidentiality as part of their induction.

Requires Improvement

Is the service responsive?

Our findings

People's care records were stored securely and could be located promptly when required. However, other records of audits completed by the head of care since the service opened could not be located on the day of the visit. These were requested but were not provided.

People's needs were assessed on admission but were not always reviewed or updated, in line with the provider's policy. We found that care provided was not accurately recorded and records did not always reflect people's current needs. For example, repositioning charts for people who were at risk of conditions such as pressure ulcers had not always been completed. Monthly observations to check people's blood pressure, temperature and pulse were not always completed. Three food diary charts we reviewed were undated making it difficult to establish when the care was given. Staff told us that care had been given but they did not always have time to record everything they did and that sometimes they did not always document monthly care plan reviews and risk assessment reviews as there were no changes to the current plans. This could impact on people as there was a lot of agency staff who would not be able to rely on the information contained in people' s care records to deliver appropriate care.

Although staff who worked in the kitchen said food temperature checks were completed daily, we found gaps in the recording of food- temperature checks which meant there was no written evidence food was served at the correct temperature. However, people told us that their food was served hot.

This was a breach of regulation 20 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some activities were provided but these did not take place regularly. People told us that they did not always have information about what was happening. On the day of our visit the activity coordinator was not on duty so no activities were offered to people using the service. Activities were scheduled to occur every Monday to Friday in the designated activity room where we saw crafts that had been made by people using the service. One person said, "When the activities happen they are good. There are a few times, like today and at weekends where nothing goes on." Another said. "I can count the number of times I have been in that room where the activities are supposed to happen." Another person said, "I like the baking sessions. I wish we could have more of those." A relative said, "I rarely see any activities going on even though I visit every day."

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. Visitors were allowed to visit at any time and were encouraged to take people out where possible. One visitor said, "I live quite close. I sometimes come twice a day if I can."

People's preferences were recorded and taken into account before care was delivered. For example, one person's care plan said they preferred female only staff for personal care support and they told us that they always received support from female staff.

People were unsure about the exact details of the complaints policy but told us that they could share their experiences or raise a concern or complaint with the registered manager. Staff told us that they would forward any complaint to the nurse in charge. The complaints policy was displayed at the main entrance and available in people's information brochures.

Complaints were acknowledged, investigated and a written response was issued in line with the provider's policy. Complaints were discussed during staff meetings to ensure that everyone was aware of current or ongoing concerns. We saw evidence that complaints and any learning from issues raised had been discussed at a staff meeting held on 5 January 2015. One relative who had complained told us that although their complaint had been acknowledged, investigated and followed by a written response their issue had not been fully resolved.

Requires Improvement

Is the service well-led?

Our findings

People using the service and staff gave mixed views about the management. Staff and relatives told us that although they could approach the registered manager at any time, they felt that issues were not always resolved. Staff gave an example of staffing levels and the lack of team work during some shifts. However, we saw evidence in the team meeting minutes we reviewed that the manager had planned an away day for staff to enable them to bond better.

When the registered manager was absent the Care Quality Commission was not always notified of significant events without delay as required. For instance, we had not been alerted to two safeguarding concerns and a death prior to our inspection. However, these had occurred within two days of the inspection. The manager had been off and told us about these on the day of the inspection and sent in notifications the next day.

Systems had been introduced to monitor the quality of care delivered although it was too early to test the effectiveness of these. The registered manager told us that satisfaction surveys were yet to be sent out. We reviewed audits completed by the registered manager and saw action plans to improve recording in relation to care plans and risk assessments, communication with relatives and staff training. There were action plans from staff meetings with assigned leads. For example, a meeting held on 7 January 2015 had identified the need to improve communication with relatives about costs related to staff attending hospital appointments, the need for further training on behaviour that challenged the service and care planning and administration support. An action plan had been developed to address these identified shortfalls.

Staff had clear roles and responsibilities and there was a staff structure which included a registered manager, a deputy manager, a clinical lead, shift coordinators, senior care staff and care staff. There were several staff vacancies at the time of our inspection including the deputy manager's post which was having an impact on the quality of the service provided. There was a recruitment plan and scheduled interviews to address this. A deputy manager was due to start in February. We were informed after the inspection that they were in post.

Regular staff meetings were used to disseminate information to staff. There were plans to hold regular meetings with relatives and people using the service and one meeting had already been held. However, people using the service and the relatives we spoke with during the inspection were not aware of this.

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
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The registered person did not ensure that people were always given a choice of suitable food to meet their individual needs.** **Regulation 14 (4) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Service users were not protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording and safe keeping of medicines used for the purposes of the regulated activity.** **Regulation 12(f)& (g)** **The registered person did not take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.** **Regulation 12 (2) (c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Service users were not protected against the risks associated with inappropriate care and treatment arising**

This section is primarily information for the provider

Action we have told the provider to take

from a lack of proper information about them by means of the maintenance of an accurate record in respect of each person which shall include appropriate information and documents in relation to the care and treatment provided to each person. Regulation 17 (2) (d).