Care Quality Commission

Larchwood Care Homes (North) Limited

Willow Brook House

Inspection report

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Corby
Northamptonshire
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15 August 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place over two days on the 12 and 15 August 2016.

Willowbrook House provides accommodation for people requiring personal care and is registered to accommodate up to 48 people. At the time of our inspection there were 46 people using the service many of whom were living with Dementia.

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

Staffing levels during the day were not always sufficient to provide safe, person centred and responsive care to people. People, staff and our observations consistently demonstrated that there were not sufficient numbers of staff deployed in order to meet people's needs.

People's individual plans of care lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences.

There were not appropriate systems or processes to assess, monitor and improve the quality and safety of the service in a timely manner. Quality assurances processes implemented by the provider were effective at identifying shortfalls, however these were not addressed in a sufficiently timely manner to minimise the impact on people.

The food provided to people living in the home was of a variable quality. People were not involved in the planning of meals and people's individual preferences were not always considered when providing meals.

Staff were not consistently caring in their interactions with people because they were rushed. Much of the interaction between staff and people in the home was task focussed because staff did not have time to have meaningful engagement with people.

People were supported by staff that had the skills and knowledge necessary to provide safe and effective care and support. People's consent was sought prior to care and support being delivered by staff.

There were appropriate recruitment processes in place and people felt safe in the home. Staff understood their responsibilities to safeguard people and knew how to respond if they had any concerns.

There were a range of activities which people told us that they enjoyed. These included one to one activities as well as group activities and days out.

People knew how to make a complaint. Where complaints had been received, these were investigated and responded to appropriately.

The registered manager was visible and approachable within the home. The local community were encouraged to play an active part in the home and were utilised to provide activities and meaningful interaction with people living in the home.

We found three breaches of regulation during this inspection. You can see the action that we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not sufficient numbers of staff to provide people with safe care and support.

People were supported to take their medication as prescribed.

People were kept safe from the risk of harm because the provider had systems in place to recognise and respond to allegations and incidents.

Is the service effective?

Requires Improvement

The service was not always effective

People did not always receive food and drinks that were of a consistently good standard.

There were procedures in place to ensure the Mental Capacity Act was fully implemented and where possible people provided consent for their care.

People were supported by staff that had access to supervision and training that was relevant to their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Staffing levels impacted upon the ability of staff to provide consistently caring support. Interaction between staff and people living in the home was at times rushed and task focussed.

Staff treated people with dignity and respected people's right to privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual plans of care were not always person centred or developed in a timely manner after they moved into the home.

There was a weekly programme of activities that people were supported to participate in.

There was information available about how to make a complaint and where complaints had been made these had been responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had systems available for the manager to review and assess the quality of service; however these systems had not been effective in driving improvements in the service.

There was a registered manager in place. People knew who the registered manager was and they were able to speak to them should they wish.

The local community was encouraged to play an active part in the service.

Willow Brook House

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 over two days on the 12 and 15 August 2016. The inspection was unannounced and the inspection team consisted of one inspector.

Prior to our inspection we reviewed the information we held about the service. This included previous inspection reports and statutory notifications sent to us by the provider. We also spoke with local health and social care commissioners to gather information about the service. Before the inspection, the provider completed a Provider Information Return (PIR) which we reviewed. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection we spoke with the registered manager, area manager, one deputy manager and four care workers. We also spoke with five people using the service and three relatives. We undertook general observations in communal areas and during mealtime. We used the 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 reviewed the care records of four people who used the service and three staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were not sufficient to ensure that people received care and support when they needed it. People consistently told us that there were not enough staff working within the home and that this meant they had to wait for care and support. People told us "There are not enough staff, you have to do without a bath sometimes," "They are very short staffed a lot of the time but all of the staff work hard" and "There are not enough staff working here, we sometimes have to wait if we need help." One person's relative said "The staff are lovely but they are rushed. I think they need more staff really." Staff working in the home also consistently told us that there were not enough staff available to support people. Staff told us "There are never enough staff. The mornings are worse but it's very busy in the evenings too" and "There needs to be more staff. We don't have time to spend time chatting and engaging with the people that live here."

Staff were rushed in their interactions with people and could not provide support to people at the pace at which they wished to be supported. We saw that one person was encouraged to speed up when transferring from their chair to a wheelchair to move to another location within the home and became distressed because they were being rushed. People were supported to spend time sat in the lounge, however staff did not have time to interact or support them effectively because people in other areas of the home required care and support. This meant that people in the lounge struggled to summon staff to provide support when they needed it. People and staff told us that staffing levels impacted on their ability to provide care to people when they wanted it. Staff told us that at times they were unable to support people to have a bath on the day they wanted to bathe and had to arrange for them to have a bath the next day instead.

The provider did not have a system in place to calculate the number of care staff required based on the dependency needs of the people living in the home. The registered manager and area manager told us that the provider was in the process of developing a tool to inform their staffing levels and help them ensure that people were supported by appropriate numbers of staff. The registered manager told us that they had identified the need for additional staffing in the morning and as a result of our feedback would increase the staffing levels throughout the day to provide additional support to people.

This was a breach of Regulation 18 (1) Staffing. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who were knowledgeable about potential risks and who knew how to protect people from harm. Staff had received training in safeguarding people and the staff we spoke to had a good knowledge of how to recognise the signs that someone may be at risk and the steps to take to escalate concerns to the registered manager or other outside agencies. One member of staff said "If I was ever concerned I would report it to the manager or other agencies like the police or the council." We saw that the provider had made appropriate notifications to the safeguarding team should they have concerns that individuals may be at risk. Where safeguarding notifications had been referred back to the provider to investigate appropriate investigations had been conducted and appropriate action taken.

People received their medicines as prescribed and were protected by the safe administration of medicines.

One person's relative told us "They always give [Relative] their tablets and help them to apply their creams in the morning and evening." We observed staff administering medicines, the member of staff checked each individuals Medication Administration Record (MAR) sheet before dispensing medication and ensured that people received the right medicines at the right time. The member of staff explained what people's medicines were for and observed people taking their medicines to ensure that they had done so safely. There were regular medicines audits where actions had been taken to improve practice. The provider had worked closely with the local care home pharmacy advice team to improve the way in which people's medicines were managed and had implemented a number of suggestions made by them. Staff administering people's medicines had received training in how to do this safely and had their competency to do this safely assessed by senior staff in the home.

Risks to people had been assessed and appropriate steps taken to mitigate any risks that had been identified. People's needs were regularly reviewed so that risks were identified and acted upon as their needs changed. Staff were knowledgeable about the risks to people and were able to describe the steps that they were taking to mitigate these risks. For example where people were identified as being at risk of pressure ulcers, the risk assessments and care plans were updated to reflect that staff carried out more frequent position changes to relieve people's pressure areas. Anyone at risk of falling had risk assessments in place and a monthly audit was undertaken around falls that had taken place in the home.

Safe recruitment processes were in place to protect people from the risks associated with the appointment of new staff. We saw that references had been obtained for new staff prior to them working in the service as well as checks with the Disclosure Barring Service (DBS).

Requires Improvement

Is the service effective?

Our findings

People's preferences in relation to their food and drink were not always known by staff or respected in the planning of people's meals. People told us that the quality of the food in the home was variable. People living in the home said "The food varies. Sometimes it's ok and sometimes it's not. We never know what we are going to have" and "The food is not nice here. But what can you do? You have to eat." The registered manager told us that they were aware the quality of the food that people received was variable and they had recently recruited a new cook and had implemented an action plan to address the quality of food that people received. People's preferences in relation to what they would like to eat were not considered when the menu for the home was devised. The registered manager told us that the cooks were not consistently following a menu and feedback from people living in the home was that they did not know what they would get for their meals until they received them. One person said "You never know what is for lunch. You just have to take it or leave it." Drinks were available during mealtimes and at set times during the day from a drinks trolley. We observed the meal time in the home and saw that people had a limited choice of what they would like to eat. People were able to choose between the main planned meal or a salad as an alternative. Staff provided support to people who needed help to eat and drink and we observed that staff ensured they supported people who needed help eating at their own pace, offering a drink throughout the meal and words of encouragement.

People were asked to give consent for their care and support and staff were knowledgeable about their responsibilities in relation to the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the registered manager had made appropriate DoLS applications to the local authority where people had been assessed as lacking capacity to be able to consent to their care.

New staff benefitted from a period of induction to ensure that they had the skills, knowledge and experience that they required to support people effectively. One member of staff who had recently commenced their employment at the home said "I completed training before I started and then got to work with my mentor who did my induction booklet with me. I also got to shadow and observe staff before I worked on my own." New staff received supervision and were observed by more experienced staff to ensure that they were competent in providing care and support to people.

People were supported by staff who had received training that was relevant to their role. Training records showed that staff had accessed training in key areas on a regular basis and that the provider had a plan in place to ensure that people training was updated periodically. Staff were able to describe how they applied

their training on a day to day basis. For example one member of staff said "I work with people that have dementia so I don't just give them choices, I show them what the choices are. Like when I offer them a drink, I show people what drinks there are so they can see them and then decide."

Staff had access to supervision and support to enable them to work effectively in their role. Records showed that prior to June 2016 staff had not received regular formal supervision from their supervisors however, the registered manager had introduced a new supervision schedule and was monitoring this to ensure that all staff received supervision on a regular basis. Records showed that since June 2016 all staff had received regular formal supervision sessions with their allocated supervisor. A new deputy manager had recently been appointed to strengthen the management team and to ensure that staff had access to effective supervision and support. One member of staff told us "I hadn't had supervision for quite a while but I had one recently and I have another one booked for next month."

People were supported to access health services when they needed to and referrals were made to people's allocated health professionals in a timely manner. One person told us "If I am feeling poorly the staff always get my GP to see me or the nurse that visits." Records showed that where other specialist assistance was required people had been referred, for example a community psychiatric nurse had attended to support with someone whose behaviour had recently changed significantly. One person's relative told us "They are very vigilant of [Name's] health and always let me know of any changes or appointments with doctors."

Requires Improvement

Is the service caring?

Our findings

Staff were unable to be consistently caring in their interactions with people because they were rushed and their practice had become task focussed. One person told us "The staff are all nice here but they are so busy". Another person said "I call the staff Roadrunner because they never have time to stop." Throughout our inspection, where we observed interaction between staff and people who used the service, it was affectionate, kind and caring. However, interaction was limited, with people mostly sat in the lounge areas on their own with the television on. We observed that people were also sat on their own in the dining area for periods of time with only limited interaction with staff. The interaction between staff and people living in the home was task focussed and at times rushed. People's preferences in relation to their daily routines and activities of daily living were not always respected by staff. People and staff told us that they could not always respect people's preferences in relation to when they were supported to have a bath and sometimes people would have to wait until the next day to have a bath due to the staff being busy.

People's dignity and privacy was maintained by staff. Staff told us how they ensured that people were treated with dignity and their privacy was maintained; for example staff explained how they would ensure that doors were closed before supporting someone with personal care tasks. They confirmed that they would know what people wanted as they would always ask the service user and any changes in needs were discussed during the handover sessions between the different shifts of staff. We observed that staff knocked on bedroom doors and waited before entering. We saw that consent was sought where possible prior to care needs being attended to.

People had been encouraged to personalise their environment to make them feel at home and comfortable. We saw that people were able to bring in personal items from their homes and we could see that a number of people had brought in their own bed, bedding and pictures of their family and friends. One person told us that they had bought in their bird table from home as they liked to watch the birds and it meant that they were able to continue to feed them in the garden.

People were supported to follow their faith and attend religious services. The Activities Coordinator explained that religious beliefs were recognised and that leaders from people's own faith could visit the service as people wished. We saw that a monthly religious service was undertaken within the home and that a Roman Catholic priest would visit on request.

Requires Improvement

Is the service responsive?

Our findings

The information contained within people's individual plans of care was inconsistent and was not always sufficiently detailed to enable people to receive constantly personalised care and support. Some documentation gave good descriptions of how people should be supported and were clear in instructing of how staff should respond to people in particular situations. However, other care plans lacked detail and were not person centred. The provider was in the process of developing a new format for care planning documentation and the registered manager told us that "The care plans are a work in progress." People's care planning documentation gave an overview of the areas where people required support however, did not provide guidance for staff to follow as to how people liked their care to be delivered. For example, one person's care plan said that they required support with their personal care however, did not provide additional instruction to staff about how to provide this support. The home provides care and support to a number of people living with dementia who would be unable to reliably direct staff in providing their care and support. This means that people were at risk of not having their care and support needs met consistently.

People were assessed prior to moving into the home to ensure that the service could meet their needs. These assessments were used to develop individual plans of care and to help staff find out about people's care and support needs. Although these assessments identified the areas where people required support, plans of care were not developed in a timely manner to direct staff in meeting people's needs. We reviewed one person's plans of care who had been living in the home for over two weeks and found that they did not have personalised care plans in place and that the preadmission assessment could not be located by staff.

Care plans and guidance lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences. This is a breach of Regulation 17 (c) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to participate in a varied range of activities. The provider employed an activities coordinator who strived to involve the local community and volunteers in providing activities to people living in the home. Throughout the home there were photos of activities that people had completed. The activities coordinator maintained a log of what activities people had completed and audited this each month to ensure that everyone living within the home had had the opportunity to partake in activities that they enjoyed.

There were systems in place to respond and deal with people's complaints. One relative said "I made a complaint once and it was responded to quickly and resolved well" We saw that people had been given a copy of the provider's complaints procedure and that a copy of this was displayed within the home. Staff were aware of the complaints procedure and told us that they would report any complaints to the registered manager and that they would respond. We saw that when complaints had been made they were investigated and responded to in line with the provider's complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

There were quality assurance procedures in place that were effective at identifying areas that required improvement however, the actions required to implement improvements were not always taken quickly enough. The provider regularly completed a range of audits including audits on health and safety and the premises. We saw documentary evidence that where any actions were identified an action plan was developed and the registered manager took steps to rectify areas that required improvement. There were systems in place to monitor the quality and safety of the service with the registered manager monitoring safeguarding notifications and accidents and incidents to try and identify any trends or patterns that may need to be addressed. The internal quality assurance procedures had identified that the food provided to people was an area that required improvement. We saw that a new cook had been recruited however, appropriately robust actions had not been implemented in a timley manner in order to ensure that people had choice and control over the food that was prepared in the home. This meant that we received consistant feedback that the food provided in the home was of a variable quality. The area manager and registered manager had also identified that people's individual plans of care were not always sufficiently personalised. The registered manager and area manager told us that they were waiting for the provider to share the new format for care planning documentation with them before implementing improvements in this area; they were not sure when this documentation would be made available. This meant that people continued to be at risk of receiving inconsistent care and support.

This inspection highlighted shortfalls in the service that had not been resolved by the monitoring systems in place. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services in a timely manner was a breach of Regulation 17 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a visible management team that was approachable and welcomed feedback from people and their relatives. Staff told us that the registered manager was approachable and felt that the home was well led. Staff told us "The manager is approachable; we can talk to her at anytime. I feel that the home is well led by them." One persons relative told us "The managers here are so approachable."

The home had developed positive links with the local community. A number of different faith churches attended the home on a regular basis and provided services to people who wished to participate in them. Local communtiy groups such as the Princes Trust and National Citzenship Service had also been invited into the home to volunteer. These groups had helped to renovate the garden into a seaside theme and to spend time with people living in the home providing people with an opportunity to mix with groups that they would not normally have the opportunity to mix with. Families and friends were encouraged to volunteer to support and take part in activities . A quarterly newsletter about recent activities, events and fund raising ideas was developed by the home and shared with people, their relatives and volunteers.

The service was being managed by a registered manager who was aware of their legal responsibilities to notify CQC about certain important events that occurred at the service. The registered manager had submitted the appropriate statutory notifications to CQC such as DoLS authorisations, accidents and

incidents and other events that affected the running of the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1)(a) There were not appropriate systems or processes to assess, monitor and improve the quality and safety of services in a timely manner. Regulation 17 (c) Care plans lacked sufficient detail to ensure people were receiving person centred care and treatment appropriate to meet their needs and reflect their personal preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) Staffing. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were not sufficient numbers of staff deployed during the day to provide safe, timely and responsive care to people.