Care Quality Commission

Young@heart (The Willows) Care Home Ltd

The Willows Care Home

Inspection report

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Ratings

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

Overall summary

The Willows care home provides accommodation for people who require personal care. At the time of our visit there were 18 people living at the home. The Willows Care home is made up of two floors. It has communal areas including a dining area and two lounges, a conservatory area and outdoor space, kitchen, manager's office and staff room. There are 25 single rooms and one double room, a kitchen and laundry facilities.

At the last focussed inspection on the 30 April and 8 May 2015 we found breaches of legal requirements were found. After this inspection we issued the provider a notice of decision to restrict admissions into the home.

The provider wrote to us to say what they would do to meet legal requirements in relation to the following breaches:

- Good governance, records and audits
- Staff training was not up to date

Summary of findings

At the previous comprehensive inspection undertaken on the 1 and 3 December 2014 we found breaches of legal requirements and found the service to be inadequate. After this inspection we issued a warning notice that they must be compliant by the 17 March 2015. The provider wrote to us to say what they would do to meet legal requirements in relation to the following breaches:

- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Managements of medicines
- Incidents and accidents

Warning notices were issued in relation to

- Assessing and monitoring the quality of service provision
- Records

This was an unannounced comprehensive inspection and took place on 10 and 11 November 2015. At this inspection there were still concerns relating to previous breaches; records were inaccurate and incomplete and there was a lack of robust quality audits and staff training to ensure staff had skills and knowledge. We also found the following breaches;

- Need for consent
- Safeguarding people from abuse and improper treatment
- Safe care and treatment
- Meeting nutrition and hydration needs

At the previous inspection we asked the provider to take action and ensure the service had a registered manager in post. At this inspection there was not a registered manager in place but the manager was being supported by a manager who was registered at a different home. 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.

People were at risk of unsafe care due to not having referrals or actions taken when there were safeguarding concerns. People's support plans and risk assessments were not always in place and did not always adequately detail what support might be required if they became anxious or upset. People were at risk of receiving medicines in an unsafe way due to inadequate records, unsafe storage, disposal and security.

People who did not have the capacity to make specific decisions did not have best interest decisions in place as required by The Mental Capacity Act 2005. People were supported by staff who had not always received training. If staff had received training they were not always able to demonstrate they had necessary skills and knowledge to undertake their role. Staff demonstrated they were supportive when people required assistance. However, people had periods of time when there were no interactions from staff. Some people benefited from activities but not everyone had the same opportunities.

People's meal time experience was not ensuring people had opportunities to socially engage with one another. People were not receiving adequate nutritional and hydration needs to meet their specific individual needs.

People and relatives felt staff demonstrated a kind and caring approach. People were supported by staff who had received necessary checks prior to employment.

Complaint records did not always show that investigations had taken place or what learning had taken place by the provider. People did not have detailed personal emergency evacuation plans in place that confirmed what support staff would need to provide or equipment required if there was an emergency.

The home did not have systems and audits in place that identified areas of concern found during this inspection. This included not identifying areas of concern within peoples care plans, assessments, the homes incidents and accident logs. There were no actions plans in place to address the concerns.

People were at risk of receiving inadequate care this was despite the support provided by the home's management team and consultancy support. We have made these failings clear to the provider and they have had sufficient time to address them. Our findings do not provide us with any confidence in the provider's ability to bring about lasting compliance with the requirements of the regulations.

The action we took is at the back of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was unsafe.

People did not have accurate records relating to risks around their care and welfare.

People were at risk of receiving medicines in an unsafe way due to inadequate records, unsafe storage, disposal and security.

Incidents were not being identified and managed to ensure people were safe and had appropriate investigation and referrals made to the local authorities.

Is the service effective?

Inadequate

The service was not effective.

People did not have appropriate assessments and best interest paperwork in place when they were unable to consent to their care and treatment.

Staff did not feel well supported and had not received training to ensure they had the skills and knowledge required for their role.

People's meal time experience was not ensuring people had opportunities to socially engage with one another. People were not receiving adequate nutritional and hydration needs to meet their specific individual needs.

Is the service caring?

Requires improvement

The service was not always caring.

People did not always benefit from staff who were able to respond to people's care needs due to them being busy completing tasks such as paperwork.

Staff demonstrated a kind and considerate approach to people's care needs and responded to people in a reassuring and calm manner when they became upset or distressed.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always have referrals made when their health needs changed.

The provider had a complaints procedure in place but these did not have adequate records that confirmed investigation details or what action and learning had occurred.

Some people had access to a range of activities but not everyone had the same opportunities and at times people went long periods of time with little interaction or activity taking place.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

Audits were failing to identify wide spread areas of concern relating to incidents, accidents, poor records, safeguarding, inadequate support plans and risk assessments and mental capacity assessments. There was no associated action plan in place that identified these shortfalls and confirmed when action would be taken.

The service at the time of this inspection did not have a registered manager in post.

Staff felt the manager was approachable. The manager confirmed the vision for the home was to address the areas of concern and build trust with professionals.

The 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 10 and 11 November 2015 and was unannounced. It was carried out by three adult social care inspectors and a specialist advisor. A specialist advisor is a person who has specific expertise. The specialist advisor used in this inspection had specific knowledge relating to people with dementia and was a qualified nurse. An expert by experience made phone calls to relatives to gain their views on the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with people living at The Willows Care Home. Some people had communication and language difficulties associated with their dementia. We therefore used 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 to us.

We spoke with the manager, the supporting registered manager, the deputy manager, seven members of staff and two senior team leaders, the administrator, two cleaners, one chef and one kitchen assistant. Following the inspection we contacted six relatives, three health care professionals and two activity co-ordinators.

We looked at seven people's care records and documentation in relation to the management of the home. This included five staff files including supervision, training and recruitments records, quality auditing processes and policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

Before our inspection we reviewed all the information we held about the home. We looked at previous inspection records, intelligence we had received about the service and notifications. Notifications are information about specific important events the service is legally required to send us. We did not request a Provider Information Return (PIR) prior to this inspection as we had received one within the last year. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make.

Inadequate

Is the service safe?

Our findings

People were not receiving safe care. At our previous inspection on the 30 April and 8 May 2015 and the 1 and 3 December 2014 we found people were at risk of inaccurate recording related to people's food and fluid charts, care plans and were at risk of developing pressure ulcerations. We issued a warning notice in December 2014 relating to those inadequate records. At the follow up inspection on the 8 May 2015 improvements had not been made so issued a decision to restrict admissions to the home. The provider sent us an action plan saying they would meet this requirement by the 14 August 2015. At this inspection we found people were still at risk of inadequate recording related to people's care and welfare.

People were at risk of not having their care needs met when they required repositioning. Two people did not receive the support they required or had charts which were accurate and completed in a timely manner. Charts were used by the service to document what support people received relating to their repositioning. For example, one person on the second day was observed for three hours on their back slightly to the left. They remained in this position until they were sat upright to eat their lunch. Records confirmed this person had been moved on their back at twice during this time. Our observations did not reflect what records confirmed. The person's care plan confirmed two hourly repositioning was required due to being at risk of pressure ulcerations. The manager confirmed this person was on two hourly turns and senior staff on duty are responsible for ensuring records were completed. There had not been checks completed to ensure records were accurate. Another person, who required two hourly turns, had only been turned twice in six and a half hours when they should have been turned four times. We spoke with the member of staff allocated to this person's care. They told us they were providing support to another person and other staff had covered them. This meant people could be at risk of developing pressure ulcerations due to not having their positions changed when required.

We found incidents and accidents were not always being recorded to ensure they could be analysed and action taken to prevent reoccurrences. For example, we found two instances in one person's daily record dated in October 2015 confirmed, 'Verbally aggressive towards staff this morning and 'very aggressive first thing'. We reviewed the recorded incidents for October 2015. The monthly overview had no record of these incidents being recorded. The provider's incident and accident policy confirmed all incidents should be recorded. We asked the manager if an incident form had been completed. They told us, "I was not aware of this". This meant not all incidents and accidents were being recorded to ensure action was taken to prevent reoccurrences and provide learning opportunities.

One person's care plan did not contain accurate information relating to the persons individual needs. The district nurse confirmed one person had significantly improved in their health and were now no longer considered end of life. Their care plan had not been updated and still confirmed, 'Small appetite due to end of life'. When we spoke with the manager they confirmed, "[Name] is end of life the district nurses are coming in". The person's care plan was last updated in September 2015. This meant they could be at risk of not having their current care needs met due to inaccurate and out of date records.

People did not have detailed personal emergency evacuation plans in place. Plans did not confirm what support staff would need to provide or the type of equipment people might need. This meant people might not have adequate support from staff in the event of an emergency.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

People did not have risk assessments and support plans in place to ensure risks were identified and managed safety. Four people were at risk to themselves and others but there were no risk assessments or guidelines in place that identified the risk or what staff should do to manage the risk. For example, one person was at significant risk of accidently harming themselves. The previous manager had notified us relating to an incident where the person had been found in a risky situation. Two staff we spoke with confirmed they were aware of this person's behaviour. However, other staff, the manager and supporting registered manager were all unaware of the risk relating to a previous incident in September 2014. Another person who could at times become upset, physically and verbally did not have a risk assessment or support plan in place yet there had been a number of physical incidents where other people had been injured. Two other people did not have risk assessments or support plans in place for incidents

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where staff had been verbally and physically injured. The manager and supporting registered manager were unable to explain why there were no support plans or risk assessments in place for these known behaviour's.

At our previous inspection on the 30 April and 8 May 2015 we found people were at risk of not receiving medicines safely as staff had not received training prior to our inspection. Action was taken by the manager on the first day of the inspection and by the second day of that inspection staff had received training. During this inspection there were still concerns with medicine management because some people were still receiving their medicines in an unsafe manner due to inadequate records, unsafe storage of keys and medicines not kept secure.

Medicines was not always stored safely as keys were not kept safe and medicines stored in the fridge were not locked. For example, the member of staff responsible for medicines did not always ensure the keys were secure and safe. On two separate occasions we observed the keys left unattended. The provider's medicine policy stated, 'The medication keys are kept on the senior person on duty and remain on that person until the handover of the shift to the next person. The keys are never left in a drawer or on a desk'. Our observations found the provider was not following their own policy.

Medicines stored in a fridge were not locked despite the provider's policy stating that it should be. Medicines stored in the fridge did not have dates to say when they had been opened so they could be disposed of once out of date. For example, there was a bottle of antibiotics, a tube of lotion and a bottle of eye drops which all had no date for when they had been opened so staff would know when to dispose of them. One person's medicines that required additional security were not securely being stored in their original dispensing packaging. This meant the procedure for administering medicines that required additional security was not being followed due to the original packaging that had been removed since leaving the pharmacy.

Medicines no longer required were not being disposed of. One member of staff confirmed the provider's destruction process but this procedure was not being followed. For example, one person's Medicine administration record (MARs) chart confirmed the person was no longer requiring some medicines however this was still available in the medicine cabinet and had not been disposed of in line with the provider's destruction process.

People did not have body maps completed when people had pain relief patches applied. For example, one person had a pain relief patch. There was no body map or records that confirmed where the last patch had been applied. Pain relieving patches are required to be rotated as per the manufacturer guidance. This meant there was a risk that people were not receiving pain reliving patches in accordance with manufacturer guidance. The provider's Medication Policy made no reference to the administration of these patches how the service would administer and record there application.

People did not have their medicines reviewed regularly, this was reflected in the MAR records. Staff were routinely not administering some medicines because people always refused them. One person still had barrier film wipes prescribed by their GP despite a member of staff telling us the person was, "Allergic to them." Two staff we spoke with regarding the administration of medicines were unable to demonstrate they had knowledge relating to people's individual medicines. For example, when one member of staff was asked why the person was prescribed cream they told us, "I don't know." This meant people could be at risk of receiving medicines from staff that were unfamiliar with why people were prescribed their medicines and has access to medicines no longer suitable.

Two people did not have a current photo within their MAR charts. One person's was photograph wearing glasses, but when staff pointed them out, they were not wearing glasses. This meant it could be difficult for staff to identify the person. Their medication plan had no confirmation as to when they wore glasses and if there were times they didn't wear them. Another person did not have a photograph in place so staff could identify who they were administering medicines to. There was no medication support plan that contained information on how people preferred to receive their medicines, such as one at a time, on a spoon or in their hand. This meant staff responsible for administering medicines might not be able to accurately identify who they were administering to or how to do it.

When people received "as required medicines" (PRN), staff were not routinely documenting why they had given the

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medicine on that occasion. This meant other staff did not have access to information that may influence when medicines were next given and for why. For example, although staff signed to indicate they had administered medication to reduce a person's agitation, there was no record of the kind of behaviour the person was displaying, or if other ways of supporting the person should be tried first. One person had been receiving pain relief during the morning medicine round and staff said this meant they were able to assist the person with their daily routine without the person being in pain. However, this was not documented on the MAR chart or a support plan within the medicines file, which meant there could be a risk that the person might not routinely receive adequate pain relief.

During the inspection staff did not follow the provider's policy and ensure they wore the medicines tabard whilst administering medicines. There was a notice confirming staff should wear this tabard. We observed no staff wearing this whilst administering medicines. One member of staff when asked confirmed, "I don't know where it is." During the medicines round staff were interrupted several times by other members of staff. This meant there was an increased risk of medication errors, and also meant that people might not always receive their medicines on time.

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

Staff responsible for administering medicines had received training and administered medicines in a sensitive manner. For example they asked people if they needed any pain relief and gave them a drink to assist with swallowing tablets reassuring people not to rush.

At our previous inspection concluded on 3 December 2014 we found the manager had failed to identify and take action relating to safeguarding incidents. Improvements had been made at the inspection undertaken on the 8 May 2015. At this inspection we found the manager had failed to take appropriate action when required in response to a safeguarding incident. For example, during our inspection we found one incident where a person had been harmed by another person in the home leaving them with a marked arm.

The manager told us, "No I have not made a safeguarding, or had conversation with safeguarding; the situation was defused at the time." We asked when they might make a referral to safeguarding. They confirmed, "Any incident that has caused damage to a resident. I didn't think a safeguarding referral was needed on this occasion as it was resolved." The provider's policy confirmed action should have been taken. We reviewed the safeguarding training the manager had attended. The last safeguarding training they attended was July 2015, this training covered the principles of safeguarding in Health and Social Care. This meant although the manager had attended safeguarding training they were not ensuring appropriate action was taken when a safeguarding incident had occurred. They had also failed to ensure a notification was to The Care Quality Commission following this incident. Following this inspection we made a referral to the Local Authority safeguarding team.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to information of concern we had received since the last inspection in May 2015, we focussed on reviewing the infection control arrangements within the home. During this inspection we found

Infection control arrangements in the home required improvement. For example, commodes were not always adequately stored and one person's room had a strong odour. The manager confirmed the room with the odour was due to have its carpet replaced in the next week. They confirmed other rooms were also due to have their carpets replaced at the same time. Most toilets and bathrooms had liquid soap dispensers and separate waste disposal bins although one toilet did not have a foot operated pedal bin which meant staff would need to use their hands to open to the bin. This bin was being used for contaminated continence pads. This represented a cross infection risk and so did the storage of commodes that were being kept in a toilet and bathroom rather than the dedicated sluice area. Both staff and the manager confirmed the sluice room had been broken and commodes were being washed in the bathroom. The manager confirmed the repair to the water leak in the sluice room had been resolved however staff were not aware the room could be used again. On the second day of our inspection the sluice room was being used.

Staff were able to demonstrate they had a good understanding of infection control. They confirmed how they protected people from the risk of infection by using personal protective clothing such as gloves and aprons when providing personal care and said these were always

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available. Two staff confirmed how they would care for a person if they had an infection. They told us, "We would put a sign up a barrier sign on the door and use our gloves and aprons." Four staff had not received infection control training. One was the house keeper however they were able to demonstrate an understanding of how to ensure people were protected from the risk of cross infection.

People's rooms were clean and daily records confirmed rooms and other areas of the home had been cleaned. However, there was no schedule or arrangements for the deep cleaning of areas of the home. This was confirmed by the housekeeper. The last Infection control audits carried out in August 2015 identified, 'deep clean required throughout the home'. There were no records that confirmed this deep clean had been actioned. A previous audit identified staff were wearing jewellery (other than wedding rings). Wearing jewellery represents an infection control risk. We observed a member of care staff wearing a number of rings and bracelets. The home's infection control policy set general methods to limit and control the potential spread of infection but it did not include staff not wearing jewellery.

Following a visit from environmental health a hygiene improvement notice had been served. This placed a requirement on the home to address failures in ensuring systems and arrangements were in place for the safe storage, preparation and serving of food. An action plan had been put in place to address the requirement. We spoke with the cook who was able to confirm actions had been taken which included implementation of a food safety policy pack, improved monitoring of food and storage temperatures and cleaning schedule.

People were supported by staffing numbers which ensured their care needs were met however we found periods of time where people went without having staff interactions. For example, there had been a significant turnover of staff in the home with only two staff confirming they had worked in the home for over eight months. During the inspection call bells were answered in a timely manner and staff were visible and easy to locate. All staff we spoke with felt there were enough staff on duty. The manager confirmed that they had increased the staffing levels in the home and that they continued to review this when people's needs change.

At least four people in the home required support every two hours with their skin integrity and care needs as well as support with their meals and drinks. We found at times people had to wait for staff to become available before they could provide them with support and assistance. For example, one person was supported by at least four different staff in a 30 minute period with their lunch whilst staff provided them with on/off assistance. This meant some people had to wait to have their support needs met and this was not always provided by the same staff to enable continuity of a positive care experience.

People were supported by staff who had undergone a safe recruitment procedure. Staff files all confirmed effective recruitment checks were in place to ensure staff had completed reference checks, application forms, interview information all retained on their staff files. Appropriate checks were undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references were obtained.

Inadequate

Is the service effective?

Our findings

The service was not effective. At our previous inspection on the 30 April and 8 May 2015 we found the provider was not ensuring staff were competent, trained and skilled to enable them to carry out their duties. They sent us an action plan saying they would meet this requirement by the 12 August 2015. At this inspection we found staff did not always receive supervision in line with the provider's policy or that they had undertaken training to ensure they had necessary knowledge and skills to undertake their role.

Some staff had not attended all training necessary to undertake their role. The training matrix record confirmed this. One member of staff, who started in October 2015, had not completed all the mandatory training set by the provider, such as moving and handling, safeguarding or fire safety. The provider's training matrix showed 11 staff needed to complete moving and handling training, safeguarding training, fire training, mental capacity training, DoLS and dementia training. Two cleaners had not completed any infection control training which was part of their role and responsibility every day.

Staff felt their eLearning training was poor. They told us, "It is boring" and "We have to do it in our own time, it's not a good way to learn" and "I find it quite hard because there is so much reading involved." The manager said they had started to invite trainers into the home for more group training. Some sessions had already taken place. Staff felt this was a positive way to learn. They told us, "We had a brilliant training session on dementia, the trainer was good," and "Training in groups is better because we get to discuss things more." We reviewed the training outcomes following the eLearning training staff had completed. We found staff made numerous attempts to gain successful pass rates of 70% or more. The manager confirmed they monitored this. They told us, "If staff needed several attempts in order to pass, we would invite them in for a one to one session to ensure their learning outcomes had been met. Where staff had taken several attempts we found no records confirmed this practice had taken place. One member of staff told us, "I don't always read the training modules, but go straight to the assessment". This meant there was a risk that some staff might not have the knowledge required to support people in a safe effective way.

Staff did not always feel well supported or that their induction and training was adequate. Staff told us, "The induction was just a list of things" and another member of staff told us, "I came and shadowed another member of staff for the day, that was it."

We reviewed the supervision new staff had received. One new member of staff had not had supervision for 5 months since starting in June 2015. The provider's supervision policy confirmed new staff should receive supervision every 3 months. Staff were unable to confirm how frequently they should be supervised. Supervision records did not always have details to gauge the level of support provided to the staff member. For example, one staff member's supervision record read, "Happy in her work, has completed all her training". The provider's supervision policy confirmed supervision sessions were aimed at providing support to staff, ensuring they understood their role and responsibilities, as well as identify any individual learning needs. Supervision records showed the provider's supervision policy was not being followed.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The service was not always effective because where people were unable to give their consent because they lacked capacity to do so the provider had not acted in accordance with 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.

For example, two people lacked capacity in daily decisions did not have an appropriate assessment and best interest decisions in place. One person had always chosen to sleep in a chair until their skin had started to break down. They were now being cared for in a hospital bed. The person was unable to consent to their care being provided in a hospital bed. One member of staff we spoke with confirmed, "[Name] used to sleep in a chair. Through talking to their family and nurses they are now cared for in an electric bed. It is much better for their skin now." The manager and supporting registered manager were both unaware this person used to sleep in a chair and that it would not be

their choice to sleep in a bed. They confirmed there was no mental capacity assessment or best interest paperwork in place for this person or who had been involved in the decision relating to them sleeping now in a bed. Another person who was unable to consent to their care had some meals modified. One member of staff we spoke with confirmed, "We liquidise [Name] food." Their care plan had no mental capacity assessment or best interest decisions in place relating to their care being provided in this way. This meant the service was not ensuring those who lacked capacity had assessments and best interest decisions as required by The Mental capacity Act 2005.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager confirmed DoLS applications had been made to the Local Authority. The manager confirmed they would chase these applications up. This meant applications had been sent and were awaiting processing.

People were at risk of not having their nutritional needs met to ensure they received a diet in line with their individual needs and wishes. We found four people were at risk of either not receiving a diet adequate to their needs; not receiving their prescribed food supplements; not having appropriate assistance with their meal; or having their hydration needs met when they became unwell. For example, one person was receiving their meals liquidised. Staff we spoke with confirmed this arrangement. They told us, "We liquidise [Name] food to a soft consistency" and "[Name] is on a soft diet." Although their care plan confirmed guidelines for staff to follow regarding modifying their lunch time meal there was no supporting guidance given by the dietitian to confirm this person should have their diet modified in this way. This meant people were not receiving care and support that was dignified or that ensured they had their nutritional needs were met.

One person who had become unwell during the first day of the inspection had not received any food or fluids for almost eight hours. The person required full assistance from staff with all their food and fluids. During the inspection we raised our concerns regarding this person's welfare. We found it took over three hours after a senior was made aware of this person's condition to call the GP. We found there was no system or alternative arrangements that could be put in place when people did not take their fluids. This meant people could be at risk of not having their hydration needs met should they be unable to take fluids by drinking them.

People were also at risk of not having their nutritional needs met due to inadequate monitoring of their weight and not receiving food supplements. For example, one person showed a weight loss but there records were not accurate in reflecting what their weight loss was. The person's professional records confirmed, 'Seen by their GP in November 2015 in response to their weight loss. Prescribed food supplements'. We found no food supplements available for this person. A staff member and manager said they did not know this person should have received food supplements. No information relating to this person receiving food supplements had been recorded as part of their diet and weight care plan. The district nurse confirmed, "Food supplements were prescribed by the GP on the 7 November 2015, this was due to 2 stone weight loss in 6 months". This meant the person had not received their food supplements as prescribed by the persons GP. Another person's records showed weight loss and their care plan stated, 'weigh four weekly". This person's records confirmed they had been weighed twice in eight months. In March 2015 they weighed 40.60 kg. In September 2015 the district nurse records confirmed the person weighed 34.55 kg. We asked the manager what the person's current weight was they were unable to tell us due to the records not being filled in.

We found people who remained in their room who required a higher calorie diet were not receiving snacks and cakes like those who were in the communal areas. We asked the staff member who was responsible for the snacks if other people who are in their rooms get snacks as well, they confirmed, "Yes they do." However our observations and records reviewed did not reflect this. This meant people could be at risk of not having their assessed nutritional needs met to ensure they had adequate food and hydration to sustain life and good health.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service effective?

People's mealtime was not a stimulating natural environment for people who were living with dementia as the environment did not create opportunities for positive interactions with other people living in the home. For example, the dining area had chairs placed around the outside of the room. This meant people were only able to talk to the person sat directly next to them unless they moved to an alternative chair. Some people living at the home were not able to make this decision and would require staff assistance should they indicate they wanted to move. The menu board was not updated until the lunch time meal was about to be served. This meant people who might require more time to decide what they would like might not be given sufficient time to make alternative decisions. Whilst some people were asked where they wanted to sit there was insufficient space at tables to enable all the people to eat their meals with others. The two tables only had enough space to sit up to nine people when there were eighteen people living in the home. We observed one member of staff complete records relating to morning care they had provided whilst people were having lunch. One person's cutlery was incorrectly laid and they struggled to eat their meal. The member of staff told us, "They were right handed," yet the cutlery had been laid for a left handed person. We also observed people being given their meal but not being told what the meal was or offered an alternative main meal or dessert. The chef confirmed that people had a choice if they decided they did not want the main meal. They told us, "We can do alternatives if people don't want the main meal, examples such as omelette, jacket potato etc." Most people would be unable to express and make decisions if they did not like a certain food. Since our inspection the manager has told us they now offer two main meal choices.

The building was laid out over two floors but some areas did not always have adequate lighting so people were more at risk of falls and accidents. For example, the main lounge area had a strip light out and the wall lights were not working and some corridors were dark even though the light was on. The manager confirmed a new strip light had been ordered, they were unable to explain why the wall lights were not working, but confirmed they would address this. The numbering of rooms was out of order and could make it difficult for people and visitors to find the correct room and not all people's rooms were identifiable with their name.

The service had regular visits from the district nursing and occupational therapy team. The manager confirmed the district nurses are visiting, "weekly at the moment". They also told us, "The occupational therapist has also spent a lot of time at the home and some people now have equipment such as bed rails in place".

Requires improvement

Is the service caring?

Our findings

The service was not always caring. Most people living at The Willows were living with dementia and were unable to tell us their views on their care. We observed occasions when people sat in communal areas and in their own rooms with no interaction from staff. Staff were always busy and there was limited opportunities to spend quality time with people that wasn't task orientated. Staff told us they would have liked to spend more time with people. One told us "We are always busy and don't get the time to sit with people as much as we would like."

Staff demonstrated a kind and caring approach. Staff had a good knowledge of each person and spoke about people in a kind compassionate, caring way. People and relatives were happy with the care and felt staff were friendly and caring. One person told us, "I am lucky to have people who care for me. I can talk to the staff and they treat me with considerable respect. People who look after us are very kind. I treat them as friends." Relatives we spoke with told us, "Staff have always been very good", "Care staff are very good", "The care here is good", "Staff are friendly and caring" and "My relative has been here 5 years, the staff are fantastic, I could not ask for better care." Staff supported people in a calm and gentle manner. For example, one member of staff encouraged a person to eat their lunch. They said, "Can you eat a bit more do you think?" and "Can you see the food ok, do you need me to get your glasses?". On another occasion a person was wearing more than one outdoor coat. A member of care staff asked about this but did so in a non-judgemental way. They asked why the person was wearing two coats and if they wanted to go somewhere or if they were cold.

Staff responded positively when people became upset reassuring people in a supportive and caring manner. In one instance a person was clearly agitated about leaving the home. Staff reassured the person in a sensitive way and were able to distract them through having a conversation that relieved the person's agitation. On another occasion staff sat and talked to a person who was confused about what they needed to do. Staff reassured them and explained what was happening confirming, "It will be dinner time soon and you can have dinner with us if you want". The person was visibly relieved saying, "That would be nice". A third person was repeatedly asking where they were and why they were here. This was carefully explained to them and they were reassured by the staff response saying, "Thank you I know now."

The majority of the people in the home needed assistance with their daily washing and dressing. Some people living in the home had facial hair. Minutes from a staff meeting in July 2015 confirmed staff had been asked to ensure that facial hair was removed. We found some people still had facial hair. Their care plans made no reference to if this was their wish to have their facial hair removed.

Staff and relatives views on the quality of care provided was generally positive, although they did feel that most of staff's time was taken up with paperwork. Staff we spoke with told us, "I'm here to make a difference. I don't ever go home worrying about the residents because I know every member of staff is competent to do their job". "I do a lot of paperwork now which takes a lot of my time up" and "I always make sure people look smart, and ask the ladies if they want to wear makeup or jewellery". Relatives told us, "Staff seem to be doing so much paperwork which has a pushed out some of the activities."

Staff respected people's privacy although some rooms were left open whilst people were sleeping in bed. All rooms in the home were used for single occupancy. When staff provided support to people doors were closed. Staff we spoke with told us, "Some people are very private so we have to take time getting to know people, I love being able to gain their confidence." All staff knocked before entering people's rooms.

Staff demonstrated a good understanding about how to respect people's dignity but we observed one person who could have had their dignity respected better. For example, one person was supported in the main lounge area with a change to their position but there was no screen provided and the person on one occasion had bare flesh showing around their middle. Staff were able to give examples of when they respected people's dignity. They told us, "I always try and respect people and maintain their dignity when I care for them. We observed when one person required assistance to respect their dignity. The staff member responded quietly and sensitively and guided the person to their room to provide the appropriate support and assistance in private.

Requires improvement

Is the service responsive?

Our findings

The service was not always responsive and ensuring that all referrals were made when people's needs changed. For example, one person had started to lose weight. No referral had been made to a professional to review this person's change in their care needs. One member of staff we spoke with told us, "I decided to modify [Name] diet because they were losing weight", when asked if they had been referred to a specialist they answered, "No". We fed this back to the manager who confirmed they would review this situation.

Although people had been given a copy of the provider's complaints procedure, details of investigations and discussions were not recorded to ensure appropriate actions had been taken. Six complaints had been received since July 2015. The complaints log confirmed responses were sent to the complainant however it was not clear how the investigation process had been followed. No details were found of completed investigations or any conversations held with staff in order to ensure there was an opportunity to improve services for people. For example, one complaint record said, "Full internal investigation took place through talking to staff and reviewing care plans". There was no evidence of the investigation or any minutes from staff discussions. Another complaint made reference to a phone call with the care home. However there were no notes in relation to the content of the phone call. This meant the provider was unable to show us how they investigated and learned from complaints when there were no detailed records to confirm actions taken.

The manager had a system in place that identified people who were at risk of falling. They reviewed the number of falls and made referrals to the occupational therapist to see if specific equipment was required. One person had been provided with floor level bed because of history of falls from their bed. Other people had been provided with bed rails and pressure mats to help in alleviating the risk of falling from their beds. Another person had been reviewed by their GP and had their medicines changed. Staff confirmed this had improved how the person responded, they told us "They are now more alert and have improved". This meant people who were at risk of falling had referrals and action taken to reduce incidents from re-occurring.

One relatives meeting had taken place during July 2015. The manager confirmed the meeting was held in order to introduce themselves. One relative at the meeting had raised concerns relating to the changes in management and that care plans had to be rewritten. Records confirmed reassurance was given from the new manager. Relatives we spoke with also expressed their views regarding the change in management. One person told us, "changes to the manager have affected [Name] they like to get to know the manager, not sure if this happens now" and "I have been concerned by the constant change of staff and the managers change a lot, care plans always seem to be re-written". No minutes were available for the meeting held during October although the manager confirmed relatives meetings were held, "Every two months".

Staff had a good understanding of how to respond to people in a person centred way. They were able to confirm people's particular interests. How they used different ways to respond to people if they were anxious or distressed. One care staff told us, "If [Name] gets agitated or restless they like to be doing tasks so we always distract them with things to do." Another staff member said how [Name] liked to be in a quiet place and if there was too much noise they would get agitated. They told us, "We offer to take them to a quieter area." A third member of staff confirmed how a person became very talkative and restless, and this sometimes meant they had a urine infection.

Some people living at the home had access to a range of activities but not everyone had the same opportunities. During observations that lasted an hour and a half a staff member was generally present in the communal lounge; there was little interaction or activity taking place with people. Staff confirmed they would have liked to spend more time with people. The manager told us, "We don't currently have an activity co-ordinator but one starts later this week". Staff felt activities could be improved. They told us, "More activities", "More going on" and "Being able to spend more time with people." One staff member told us "There should be more 1:1 activities." Some staff managed to undertake activities in-between their care duties. For example, one person had assistance from staff to pick their horses and place bets on horses. They told us this was an interest they had. Another person participated in folding the laundry which the person did for some time. We were told by other members of staff how this person enjoyed undertaking tasks and how this was a way to help them settle and relieve their restlessness.

Requires improvement

Is the service responsive?

People and relatives had been asked to fill in a 'This is me' document. These were held in the persons care plan. The document gained views and information on what was important to that person, such as family, lifestyle, career, foods and music. This meant people and their relatives were involved in their care planning.

Inadequate

Is the service well-led?

Our findings

At our last inspection on the 30 April and 8 May 2015 and the 1 and 3 December 2014 we found the provider was not ensuring audits identified areas of concern in relation to incidents and accidents. Some incidents related to injuries documented in people's care plans, daily records and body maps and medication incidents. We issued a warning notice in December 2014 relating to audits failing to identify concerns and lack of clear action plans and at the follow up inspection on the 8 May 2015 we found improvements had not been made so there was a decision to restrict admissions. The provider sent us an action plan saying they would meet this requirement by the 14 August 2015. At this inspection we found people were still at risk due to audits failing to identify areas of concern found during this inspection.

We found records relating to people's risk assessments and support plans were not in place to ensure risks were identified and being managed safety. Records were not up to date relating to people's weights. Incidents and accidents were not always being recorded to ensure they could be analysed and action taken to prevent reoccurrences. One person's care plan did not contain accurate information relating to the persons individual needs. For example, the person had been considered as nearing the end of their life were now considered not to be. Two other people did not have an appropriate assessment and best interest decisions in place relating to them sleeping in a chair and their diet being liquidised. The manager confirmed audits were conducted on the 9 and 10 November 2015 of people's care plans. They shared the outcome of these audits with us. The audits failed to identify areas of concern found during this inspection. We spoke with the manager about where they felt the service was at regarding meeting their action plan. They told us," I need to get my head around the audits, I have been spending so much time in the office. I am looking forward to getting to grips with the care plans".

The provider's recent medication audit completed 29 October 2015 scored a 100% satisfaction rate. However, we found the audit findings did not correlate with our findings or observations during our inspection. We found the service was not ensuring people received their medicines in a safe manner due to inadequate records, unsafe storage of keys and medicines not being securely locked. For example, one audit question asked if there was a recent photograph of all the residents on the MAR chart. This had been ticked as compliant, but there was one photograph not in place, and it was unclear how the auditor would assess if the photographs were recent as they were not dated. There had been no new admissions into the home since the completion of this audit. This meant the audits had failed to identify this missing MAR chart record. The audit also confirmed that as required and refused medicines were being recorded on the reverse of the MAR charts. We found this was not consistently undertaken by staff and during the inspection we had to prompt one member of staff to do so during one of the medicines rounds.

A medicines audit undertaken on the 14 September 2015 highlighted that GP medicine reviews were required, but we found these had not yet taken place. The audit also highlighted that "Opened on" dates must be recorded on eye drops and creams. We found this practise was not being consistently implemented as items in the fridge had not been dated. Additionally, items in the fridge which had been labelled had not been discarded when they had expired. This meant there was a risk that staff were not consistently checking the dates of when items had been opened to ensure they had not expired. Staff were not ensuring keys were safely kept on their person and the fridge had failed to be identified that it was not being securely locked. This meant the provider was not ensuring people were protected by ensuring audits identified areas of concern and there was a clear associated action plan in place.

The manager was failing to ensure where people were at risk of weight loss this was accurately recorded and being managed. We talked to the manager regarding the shortfalls in the weight records completed for the month of October. Three people were at risk of weight loss and required their weight to be monitored. The record had not been filled in to show their weight taken in October or September. At their weight taken in August 2015 one person had been identified as losing a significant amount of weight. When talking to the manager what the recent weight was for this person they were unable to find any records and told us, "The district nurses are weighing [Name]". On talking to the district nurse they confirmed the

Inadequate

Is the service well-led?

home were responsible for weighing people. This meant there was no record for three people who were at risk of losing weight and this had failed to be identified with a clear action plan confirming what action would be taken.

The manager confirmed there was an action plan in place to address some areas in the home such as carpets that had an odour. However, the infection control audit failed to identify other areas found during this inspection. For example, we found equipment was not always adequately stored and the sluice room was not being used. Lights were not working on the wall in the lounge and some bulbs were out in the back corridor upstairs. There were also no deep clean schedules in place to confirm when staff had undertaken a deep clean. There was a lack of hot water in a number of ground floor rooms. A member of staff ran one person's tap for over five minutes, no water came through and they had to go elsewhere for the hot water. There was no audit in place that identified these shortfalls or an action plan confirming what action would be taken.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

The provider had appointed a new manager in June 2015. The service had not had a registered manager in post since July 2014. Since this time the service has been managed by two different managers. The current manager had submitted an application form to register as the registered manager. At the time of this inspection no decision had been made regarding the registration of this individual.

The manager confirmed their vision for the home was to address the areas of concern and to build trust with professionals. They told us, "I did not realise the extent of what I had to manage. We have worked hard and building trust with professionals".

We asked staff about the management of the home. They told us the manager was approachable. One told us how they made a complaint and the manager had responded in a positive way. One member of staff told us, "It has got better". Another member of staff described the manager as, "Professional, I feel comfortable talking with her." A third staff member said, "It feels like it is getting to be a better place."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's rights were not protected due to lack of capacity assessments and best interest decisions as required by the Mental Capacity Act 2005.

The enforcement action we took:
Cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected from abuse through systems and practices in the service or improper treatment. Regulation 13 (1) (2) (3)

The enforcement action we took:
Cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Planning and the delivery of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. Care plans had not been updates as people's needs had changed. This meant that up to date information about people's care and support was not always available. People were at risk due to medicines not having suitable storage, disposal and records.

This section is primarily information for the provider

Enforcement actions

Regulation 12 (2) (a) (b) (g)

The enforcement action we took:
Cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs People were not receiving prescribed and modified diets in line with their individual care needs.

The enforcement action we took:
Cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found the registered provider had not protected people against the risk of inaccurate and incomplete records. We found that the register provider had not protected people by ensuring audits identified areas of concern found during this inspection. 17 (1) (2) (a) (b) (c)

The enforcement action we took:
Cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider had not protected people by ensuring staff were suitability competent, trained and skilled to enable them to carry out their duties.

This section is primarily information for the provider

Enforcement actions

18 (1) 2) (a)

The enforcement action we took:
Cancelled the provider's registration.