

# Unity Homes Limited

# The Willows

## Inspection report

1 Murray Street  
Salford  
Greater Manchester  
M7 2DX  
Tel: 0161 792 4809  
Website:

Date of inspection visit: 15 December 2014  
Date of publication: 12/02/2015

### Ratings

#### Overall rating for this service

Requires Improvement



Is the service safe?

Inadequate



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Requires Improvement



Is the service well-led?

Requires Improvement



### Overall summary

The Willows provides residential and nursing care for older people. It is registered to accommodate up to 124 people. The home consists of two detached properties at the same address. The first detached property known as 'The Willows,' provides mixed residential and general nursing care across two floors. The second property known as 'Bluebell Court,' provides residential care on its first floor unit and nursing care on its ground floor unit for people with dementia/mental health conditions. At the time of our visit, there were 45 people resident at 'The Willows' and 49 people resident at 'Bluebell Court'.

We undertook a scheduled inspection of the service on 06 May 2014, when we found the service was non-compliant with regulations in respect of the management of medicines and record keeping. We undertook a follow-up inspection on the 22 September 2014 to see how the service had addressed the regulatory non-compliance. We found the service was now compliant with regulations in respect of record keeping. However, it remained non-compliant with the management of medicines. We also found it non-compliant with regulations in respect of the care and welfare of people who used the service.

# Summary of findings

Because of our concerns for the safety of people that used the service, regarding the continued non-compliance with the management of medicines, we served a warning notice on the provider. This required the service to become compliant with Regulation 13 of the Regulated Activities Regulation 2010 regarding the management of medicines by the 01 November 2014. The service then wrote to inform us that improvements would be made by assessing the competency of the nurses who would be checking records at the end of their shifts and that an external consultancy firm would audit medicines each month. They told us better systems would be in place for ordering medicines and creams and that protocols would be put in place to make sure people were given their 'when required' medicines safely.

There was no registered manager in place at The Willows (including Bluebell Court) when we undertook our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law. The home had been without a permanent registered manager for over 18 months, though efforts had been made to recruit a registered manager during that period, whilst a temporary manager in post. Shortly before we undertook this inspection, the provider was able to confirm that a new manager had now been appointed and was scheduled to take up their post early in 2015.

During this inspection we found two breaches of regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During our visit we checked to see if improvements had been made in the way the service handled medicines to ensure people were protected against the risks associated with the unsafe use and management of medicines. We found that though some improvements had been made since our last visit in September 2014, overall insufficient progress had been made. We found that medicines were still not handled safely.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because the service did not protect people against the risk associated with the unsafe use and management of medicines.

We are currently considering what action to take against the service in respect of the continued failure to meet regulations in respect of medication.

During our inspection we looked at five care files on the Bluebell Court Unit. We found that none of the care planning agreement forms, consent for photograph forms and consent to access service user's note by other agencies had been signed and dated by the person who used the service or their representative. The service could therefore not clearly demonstrate they had consistent arrangements in place for the recording of people's consent.

This is a breach of Regulation 20 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010, because the service had failed to maintain accurate records of people who used the service.

People from across the home told us they felt safe at home.

Staff we spoke to were able to confirm they had received training in safeguarding adults, which we verified by looking at training records. They were able to describe to us what action they would take if they had any concerns and were aware of the service's whistleblowing policy.

We looked at how the service ensured there were sufficient numbers of suitably qualified staff on duty to meet people's needs. On the day of our visit we found there were sufficient numbers of staff on duty across the three units to meet the needs of people who used the service. We received a mixed response from people regarding staffing levels. We spoke to the provider about the staffing concerns raised by relatives. They acknowledged that there had been difficulties with recruitment and continuity of staff. However, they stated that following recent recruitment, reliance on agency staff had reduced and consistency of staff and staffing levels had improved and that staffing levels were being monitored on a daily basis.

We found care plans reflected the current health needs of each person and provided clear instructions to staff regarding the level of care and treatment required. Staff we spoke to were able to demonstrate a good understanding of each person's needs and the care and support required.

# Summary of findings

It was apparent the service worked well with other health care services to ensure people who used the service had their individual needs met.

Improvements were required to ensure signage was better suited to meet the needs of people suffering with dementia. We recommend the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

We looked at training records to ensure staff were fully supported and qualified to undertake their roles. Staff explained that they have had a comprehensive induction followed up by a set of mandatory training. Staff were able to tell us that they received regular supervision and felt supported in their role.

We found that individual nutritional needs were assessed and planned for by the home.

Throughout the inspection, we observed staff treating people with respect and dignity. We saw staff supporting people in a sensitive, respectful and considerate manner. We observed good humoured interactions between staff and people in the lounges.

From looking at care files we tracked choices, like and dislikes within care plans of people who used the service. We spoke to staff who were able to speak knowledgeably about the people they cared for. We observed staffing knocking on bedroom doors before entering. Staff were patient, friendly, supportive and used people's name when speaking to them.

The home undertook an initial assessment prior to admission involving the person and their family to determine what the person's individual care and treatment needs. We found people's needs were assessed and care and support was planned and delivered in accordance with people's wishes.

We observed one person becoming very agitated and aggressive towards staff at one stage during our visit in the Bluebell Court Unit. We saw staff dealt with the situation professionally, calmly and effectively whilst ensuring the safety of other people who used the service.

We found no set activity programme in the Blue Bell Court on the day of our inspection and observed very little in the way of mental or physical stimulation was available for people. We observed people sitting in one of the lounges, the TV was on but no one was watching it. Improvements were required to ensure greater consistency and continuity across the home to ensure people had opportunities to take part in activities they enjoyed and met their personal preferences.

Concerns were expressed about communication between families and management. Relatives were concerned that no recent resident and family meetings had taken place. Improvements were required to ensure the service effectively engaged with relatives to ensure they were kept fully informed and updated about any developments within the home, which impacted on the care their loved ones received.

Both people who used the service, their families and staff were able to confirm that the provider maintained a visible presence throughout the home and was always available to deal with any issues.

We found the home currently had separate Investors in People recognition for both The Willows and Blue Bell Court.

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. We found that regular reviews of care files and care plans were undertaken. We looked at monthly infection control audits that were undertaken. However, improvements were required to ensure auditing processes remained effective specifically in relation to medication and obtaining formal written consent from people who used the service.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that CQC had received all the required notifications in a timely way from the service.

# 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?

The service was not safe. During our visit we checked to see if improvement had been made in the way the service handled medicines to ensure people were protected against the risks associated with the unsafe use and management of medicines. We found insufficient progress had been made by the service and we found that medicines were still not handled safely.

People from across the home told us they felt safe at the home.

We received a mixed response from people regarding staffing levels. We spoke to the provider about the staffing concerns raised by relatives. They acknowledged that there had been difficulties with recruitment and continuity of staff. However, they stated that following recent recruitment, reliance on agency staff had reduced and consistency of staff and staffing levels had improved and that staffing levels were being monitored on a daily basis.

Inadequate



### Is the service effective?

Not all aspects of the service were effective. Of the five care files we looked at on the Bluebell Unit, we found none of the care planning agreement forms, consent for photograph forms and consent to access service user's note by other agencies had been signed and dated by the person who used the service or their representative. The service could therefore not clearly demonstrate they had consistent arrangements in place for the recording of people's consent.

We found care plans reflected the current health needs of each person and provided clear instructions to staff regarding the level of care and treatment required. Staff we spoke to were able to demonstrate a good understanding of each person's needs and the care and support required. It was apparent the service worked well with other health care services to ensure people who used the service had their individual needs met.

Improvements were required to ensure signage was better suited to deal with the needs of people suffering with dementia. We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

Requires Improvement



### Is the service caring?

We found the service was caring. Throughout the inspection we observed staff treating people with respect and dignity. We saw staff supporting people in a sensitive, respectful and considerate manner. We observed good humoured interaction between staff and residents in lounges.

Good



# Summary of findings

From looking at care files we tracked people's choices, like and dislikes within care plans of people who used the service. We spoke to staff who were able to speak knowledgeably about the people they cared for. We observed staff knocking on bedroom doors before entering and were patient, friendly and supportive. We observed staff using people's names when speaking to them.

We observed family members visiting during the day without any restrictions. They were made to feel welcome by staff and offered drinks during their visit. Both people who used the service and their relatives told us they were involved in determining the care received and were involved in later reviews.

## Is the service responsive?

Not all aspects of the service were responsive. The home undertook an initial assessment prior to admission involving the person and their family to determine what the person's individual care and treatment needs. We found people's needs were assessed and care and support was planned and delivered in accordance with people's wishes.

We observed one person becoming very agitated and aggressive towards staff at one stage during our visit in the Bluebell Court Unit. We saw staff dealt with the situation professionally, calmly and effectively whilst ensuring the safety of other people who used the service.

We found no set activity programme in the Blue Bell Court on the day of our inspection and observed very little in the way of mental or physical stimulation was available for people. We observed people sitting in one of the lounges, the TV was on but no one was watching it. We found improvements were required to ensure people accessed activities and social interactions that met their personal preferences.

**Requires Improvement**



## Is the service well-led?

Not all aspects of the service were well-led. There was no registered manager in place at The Willows (including Bluebell Court) when we undertook our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law. The home had been without a permanent registered manager for over 18 months, though efforts had been made to recruit a registered manager, whilst a temporary manager was in post.

Shortly before we undertook this inspection, the provider was able to confirm that a new manager had now been appointed and was scheduled to take up their post early in 2015. Both people who used the service, their families and staff were able to confirm that the provider maintained a visible presence throughout the home and was always available to deal with any issues.

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. We found that regular reviews of care files and care plans were undertaken. We looked at

**Requires Improvement**



# Summary of findings

monthly infection control audits that were undertaken. However, improvements were required to ensure auditing processes remained effective specifically in relation to medication and recording consent from people who used the service.

# The Willows

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on the 15 December by three adult social care inspectors, one pharmacy inspector and an expert by experience. An expert by experience is a person who has experience of or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also liaised with external professionals including the local vulnerable adult safeguarding team, the local NHS infection and prevention

control team and NHS Salford Clinical Commissioning Group. We reviewed information sent to us by us by other authorities. We reviewed previous inspection reports and other information we held about the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with 10 people who lived at the home, 10 visiting relatives, and 16 members of staff. Throughout the day we observed care and support being delivered in communal areas that included the lounge and dining areas, we also looked at the kitchen, bathrooms and people's bedrooms. We looked at the personal care and treatment records of 11 people who used the service, staff supervision and training records, medication records and the quality assurance audits that were undertaken by the home.

# Is the service safe?

## Our findings

People from across the home told us they felt safe living at the home. One person who used the service told us; “I am happy here. I feel safe here, definitely. The staff have been great up until now.” Another person who used the service said “I feel alright. I don’t feel worried about anything.” Other comments from people who used the service included; “I feel quite safe. I get on with some staff but not with some.” “It is always clean and smells nice.”

During our visit we checked to see if improvements had been made in the way the service handled medicines to ensure people were protected against the risks associated with the unsafe use and management of medicines. We found that though some improvements had been made since our last visit in September 2014, overall insufficient progress had been made by the service and we found that medicines were still not handled safely.

We looked at medication records for 26 people who were living at the home on the day of our visit. We saw that improved arrangements were in place for ordering medicines, which were prescribed each month. However, further improvement was needed, because we found that one person had been prescribed a new medication, but staff had not ensured it had been obtained in a timely manner. It had not been made available until 10 days after it had been prescribed. We found another instance of a person who had missed a dose of their medicine, because the service had not arranged for their medicine to be supplied in a timely manner.

In some bedrooms in the Bluebell Court unit, small lockable spaces had been provided so creams could be kept safely in people’s bedrooms. However, the lockable spaces were too small to keep some large tubs of creams and we saw these were still kept in bedrooms without risk assessments in place to show it was safe to do so.

We found, as at the last inspection, that medicines were not administered safely. We saw the morning medicines round was not completed on one unit until after 10:30am. We saw one person was given a dose of their Paracetamol at the end of the medication round. The lunch time medicines round was completed by 1:20 pm and we saw that same person was given another dose during the lunch

time round. This meant they were given doses of Paracetamol too close together. There were no arrangements in place to ensure doses of medicines as in this instance were given after set time periods.

We saw that almost all of the 26 people whose records we looked at were prescribed at least one medicine to be taken ‘when required.’ We found that all medicines prescribed in that way did not have adequate information available to guide staff on to how to give them. We found there was no information recorded to guide staff on which dose to give when a variable dose was prescribed. It was important this information was recorded to ensure people were given their medicines safely and consistently at all times.

We found there was still limited information recorded to guide staff as to where to apply creams to ensure people were given the correct treatment. When information was available, we saw the records showed that staff had not applied creams properly.

We saw staff sometimes failed to follow the prescriber’s direction fully and people were not given their medicines properly. We saw that one person was prescribed some thickener to ensure that they did not choke when drinking fluids. We found the information was conflicting and staff were thickening their drinks to a different consistency than was recorded in their care plan and other records. We saw another person was given double their prescribed dose of medication but no reason was recorded as to why the extra dose had been given.

We found arrangements to give people their medication as directed by the manufacturers, especially with regard to food had still not been made. We saw that medicines which needed to be given before food were given with medicines which should be given with or after meals. Medicines must be given at the correct times to make sure they work properly.

We saw some people needed to be given their medicines covertly. We found inadequate information was available to guide staff as to the best way to hide medicines so that they were taken safely.

We found appropriate arrangements were still not fully in place in relation to the recording of medicines. We saw that the records about medicines were generally well



## Is the service safe?

completed. However, we found little reliance could be placed on records about creams, because senior care staff signed records indicating they had applied creams, while in fact other care staff had applied the medication.

When we compared medication stocks with the records we found that medication could not always be accounted for. It was therefore difficult to establish from some records if people had been given their medicines properly. We saw that some people still did not have photographs with their medication record sheets. Photographs are needed to help staff identify people. This was important on the day of our visit, because two nurses who had not worked in the home for many months were on duty administering medicines.

We saw some audits about medication had been carried out but were limited in scope and were not effective as they did not identify any of the concerns we found during our inspection.

This is a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, because the service did not protect people against the risk associated with the unsafe use and management of medicines.

We looked at how the service managed safeguarding concerns and protected people against abuse. We looked at the service safeguarding adult's policy and procedure, which described the procedure staff could follow if they suspected abuse had taken place. Safeguarding contact numbers for the local authority and the Care Quality Commission (CQC) were displayed on the wall in the main reception area. Staff we spoke to were able to confirm they had received training in safeguarding adults, which we verified by looking at training records. They were able to describe to us what action they would take if they had any concerns and were aware of the service's whistleblowing policy. One member of staff told us; "I do believe people are safe here in a friendly environment. If I had any concerns I would approach the senior management or Police if need be."

We looked at a sample of 10 staff recruitment files and found each file contained records, which demonstrated that staff had been safely and effectively recruited. Appropriate criminal records bureau (CRB) disclosures or Disclosure and Barring Service (DBS) checks had been undertaken and suitable references obtained.

We found there was a range of risk assessments in place to keep people safe from harm. These included nutrition; falls; skin integrity; urinary continence; oral; cognitive and personal hygiene. For example, we saw the wide use of airflow mattresses and cushions to reduce the likelihood of pressure sores. We found a personal emergency evacuation plan had been completed for each person staying at the home in the event of any emergency occurring.

We looked at how the service ensured there were sufficient numbers of suitably qualified staff on duty to meet people's needs. On the day of our visit we found there were sufficient numbers of staff on duty across the units to meet the needs of people who used the service. For example, in the Willows Unit we found there were seven care staff, one senior member of care staff, one nurse and an activities coordinator on duty to support 45 people. However, we received a mixed response from people regarding staffing levels. One visiting relative told us; "A few times I have come and there are no members of staff in the lounge. Another relative has already raised concerns about staff levels." Another relative said "X is safe, but when there is a lack of staff I worry about some of the more demanding residents. One resident causes some problems for others."

A visiting relative to the Bluebell Court Unit told us there were not enough staff available for the number of people supported. Other concerns related to the turnover of staff. One relative told us; "Turnover of staff happens a lot." Another relative said "There is a lot of turnover of staff. They get to know someone and then they've gone." Other comments included; "There have been concerns over staff turnover but it is a bit more stable now." "I feel they need more staff. Sometimes you can come in and you are wandering about looking for staff." "The continuity is unbelievably poor. The turnover of staff is huge."

We spoke to staff about whether they had any concerns about staffing levels. We were told that while there had been problems earlier in the year things had settled down with staffing numbers. One member of staff told us; "I think there is enough staff now, if numbers increase the management will always increase staff numbers. The management is very approachable and are extremely good at increasing staffing numbers if required." Another member of staff said "At the moment staffing is ok. If

## Is the service safe?

numbers increase the management will simply increase staff numbers.” Other comments included; “No concerns about staffing.” “Management are very flexible about increasing staff as need determines.”

We spoke to the provider about the staffing concerns raised by relatives. They acknowledged that there had been

difficulties with recruitment and continuity of staff. However, they stated that following recent recruitment, reliance on agency staff had reduced and consistency of staff and staffing levels had improved and that staffing levels were being monitored on a daily basis.

# Is the service effective?

## Our findings

People and their relatives told us they consented to the care and support that was provided by the service. On the whole, we witnessed staff seeking consent from people before undertaking any tasks or explaining to people what they needed to do before undertaking a task such as supporting people when eating. However, during our inspection we looked at twelve care files. Of the five care files we looked at on the Bluebell Court Unit, we found none of the care planning agreement forms, consent for photograph forms and consent to access service user's note by other agencies had been signed and dated by the person who used the service or their representative. The service could therefore not clearly demonstrate they had consistent arrangements in place for the recording of people's consent.

This is a breach of Regulation 20 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2010, because the service had failed to maintain accurate records of people who used the service.

We found care plans reflected the current health needs of each person and provided clear instructions to staff regarding the level of care and treatment required. Staff we spoke to were able to demonstrate a good understanding of each person's needs and the care and support required. We witnessed a morning hand-over briefing conducted by the night duty nurse with the morning team. An update was provided in relation to each person who used the service and covered what type of night they had, whether there were any particular needs and whether they were up, washed or dressed.

It was apparent the service worked well with other health care services to ensure people who used the service had their individual needs met. GP and other health care professional appointments and visits were recorded in care plans demonstrating a multi professional approach to providing care for people who used the service. A relative's communication record in each care file ensured families were kept informed and updated about any developments with their loved ones.

In the residential unit of Bluebell Court, the service had a dedicated sensory room, which people could use whenever they chose. We saw people using this facility throughout the day during our visit. Throughout the three units, most

people who used the service suffered from varying degrees of dementia and were at times confused and disorientated. We found the home did not have signage features that would help to orientate people with this type of need. We saw that people who used the service were able to wander about the corridors. Improvements were required to ensure the signage was better suited to deal with the needs of people suffering with dementia.

**We recommend that the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.**

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Care home providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm.

We saw there were procedures in place to guide staff on when a DoLS application should be made. We looked at mental capacity tools kit used by the service to determine capacity and whether a DoLS application was required. We saw a completed request for a DoLS application that had been submitted, which was awaiting a response. We spoke with staff to ascertain their understanding of the Mental Capacity Act (2005) and DoLS. We found staff demonstrated a good understanding of the legislation and had either received training or were scheduled for training, which we verified from looking at training records.

We looked at training records to ensure staff were fully supported and qualified to undertake their roles. Staff explained they have had a comprehensive induction followed up by a set of mandatory training selected by the provider. Training undertaken by staff in the last year included; Manual Handling; Hygiene; Safeguarding; Health and Safety; Dementia; Fire Safety and Infection Control. A number of staff explained that they have already achieved or were working towards a National Vocational Qualifications (NVQ) level 2 or level 3. We also checked to ensure that nurse's professional registrations with the Nursing and Midwifery council was current, which we confirmed from reviewing training records. We were told

## Is the service effective?

that a training coordinator arranged and scheduled training for all staff across the home. We looked at a training matrix which detailed what training staff had received and future scheduled training needs.

We looked at supervision and annual appraisal records and spoke to staff about the supervision they received. Supervision and appraisals enabled managers to assess the development needs of their support staff and to address training and personal needs in a timely manner. Staff were able to tell us that they received regular supervision and felt supported in their role. Comments from staff included; "I feel very supported in what I do. I get plenty of training also." "I believe I have been given plenty of training and support to undertake my role." "I have supervision every two months." One member of staff felt communication was poor and told us; "Things have been difficult with the changes in managers, but I'm confident if I approach the provider they would support me. Communication is not good at times. We haven't had a staff meeting for ages."

During our inspection we used the Short Observational Framework for Inspection (SOFI) during lunch. We observed lunch in all units across the home. We noted that as people entered the dining rooms they were asked where they wanted to sit. Where people became agitated whilst awaiting their meal we saw care staff interact and reassure people. A menu board displayed the choices of food available.

People were asked what they would like and we observed positive interactions between staff and people during the lunch time experience where people were encouraged to eat and drink in a friendly and reassuring manner. There was both a choice of main meals and puddings. We also saw people provided with special diets such as pureed meals. Staff encouraged people to be independent during mealtimes, but were supported with eating where required. We found some people waited over 30 minutes for their meals, which could have been avoided by a more focused approach by staff.

We asked people what they thought of the food they were provided with, comments included; "It's lovely this dinner. It always is." "The food is quite good. I can't grumble." "The food is always good. We like the sausage and mash." "The food is good. We used to get one choice, soup and sandwiches, but a new lady has come and now we get two choices." "Lately they've had a new cook and she's very good. Lately there's been variety."

We looked at care files and found that individual nutritional needs were assessed and planned for by the home. We saw evidence that people who were assessed as being at nutritional or hydration risk, had the relevant fluid balance and food charts in place and we saw that these were completed correctly without gaps.

# Is the service caring?

## Our findings

Throughout the inspection we observed staff treating people with respect and dignity. We saw staff supporting people in a sensitive, respectful and considerate manner. We observed good humoured interactions between staff and residents in lounges. People told us that staff were caring and helpful. Comments from people who used the service included; “I have trouble getting comfortable in bed so they have given me a fold away chair to sit in at night.” “The carers are good, sometimes. Sometimes they say hello but sometimes they are a bit distant with me. There are one or two staff I don’t like.” “I’m quite satisfied with the place.” “You get up at what time you want. It’s better than home.” “This is a great place. The staff are great. If you want something they’ll get it for you.”

One visiting relative told us; “My X had a stroke. They do everything for her. They have to hoist her. She gets physio five days a week.” Another relative said “The care is excellent. The staff are brilliant. Sometimes there are blips in the number of staff on duty.” Other comments from family members included; “The carers are great, in general.” “One of the carers is very good. He listens to our needs.” “The permanent staff are great but there are not enough of them. They kept getting agency staff in and they are not as good.” “I’ve never had any qualms that X wasn’t being looked after.” “We come every Tuesday. I admire it for its cleanliness. Her room is kept nice. She is always clean.”

From looking at care files we tracked choices, like and dislikes within care plans of people who used the service. We spoke to staff who were able to speak knowledgeably about the people they cared for. We observed staff knocking on bedroom doors before entering and were patient, friendly and supportive. We observed staff using people’s names when speaking to them.

One visiting relative raised concerns regarding the English language ability of some members of staff, which they

believed impacted on their ability to be understood by people who used the service. We were told “Because of frequent changes in staff over the last six months, lots of staff don’t speak English. I don’t understand them, so how can my X understand them?”

We observed interactions between staff and with one person who used the service, whose first language was not English and who had become very agitated and upset. A member of staff who was able to speak this person’s language and was able to engage effectively with them, which reduced their anxieties and calmed them down. We were told that there were two members of staff that could speak that language and there was usually one on shift to meet that person’s linguistic needs. This demonstrated the home were able to provide an enhanced level of care by meeting the linguistic needs of a person who used the service.

We observed family members visiting during the day without any restrictions. They were made to feel welcome by staff and offered drinks during their visit.

Both people who used the service and their relatives told us they were involved in determining the care received and were involved in later reviews. It was clear from looking at care files that people or their representatives had been involved in developing information about people’s personal history, preferences and favourite things. This included detailed consultation during pre-admission assessment by the service before admission into the home. One relative told us “We’ve had meetings with the home and social services. The home keeps us informed and have phoned us when there have been problems.”

We found care files contained evidence of advanced care planning discussions with the person or their representatives to determine the way they would like to be cared for at the end of their lives.

# Is the service responsive?

## Our findings

We spoke to people and relatives about the opportunities for physical and mental stimulation at the home. Comments included; “We’re having a Christmas party on Wednesday. It’s a buffet. We have fish and chips on Fridays.” “The activities aren’t as good as they should be. The activities co-ordinator works 8am to 2pm, five days a week. If they are short of staff she does a carer’s role instead of doing activities. Stimulation is not as good as it might be. Activities would improve the home.” “There is little stimulation. They have done her nails a couple of time, but not many, There are no pictures of my X doing any of the activities.” “There’s a lady who does activities but when they are short of staff she goes on caring. They’re not stimulated a lot. They need more activities.”

“I think the staff are very nice but the residents don’t seem to get much stimulation.”

A number of people raised concerns about the absence of outside visits for a number of months. Comments included; “X looks after the games. I’ve not been out for six or seven months. They used to take us out once a week. They say the van’s off the road.” “I’ve not been out for months. They said something about taxing the van. We used to go out regularly.” “The minibus has not moved for 3 months.”

We found no set activity programme in the Blue Bell Court on the day of our inspection and observed very little in the way of mental or physical stimulation was available for people. We observed people sitting in one of the lounges, the TV was on but no one was watching it.

Within the Willows Unit, we saw structured activities had been organised including Christmas themed arts and crafts. A Christmas party had been arranged for the 16 December, which included live music. A noticeboard within the unit contained photographs of activities people took part in. Care files for people included details of socialisation and an activity record of what they had been involved.

We spoke to the full-time activities coordinator for Blue Bell Court. They explained that they divided their time between the two units within Blue Bell Court on alternative days. They would engage in pamper days which consisted of make-up and nail care. Healthy hearts and hip exercises

tool place every Wednesday and on the afternoon of our inspection they would be making Christmas cards and baking. We were also told that they watched a film every Friday where popcorn was provided.

We were told that there was currently no outside trips as the mini bus driver needed to renew their driving licence. We spoke to the provider about this matter, who stated that the driver was currently on leave, but the issue would be addressed on their return to ensure outside trips could resume. We found improvements were required to ensure greater consistency and continuity across the home to ensure people had opportunities to take part in activities they enjoyed and met their personal preferences.

The home undertook an initial assessment prior to admission involving the person and their family to determine what the person’s individual care and treatment needs. We found people’s needs were assessed and care and support was planned and delivered in accordance with people’s wishes. We looked at a sample of 12 care files. Care plans provided clear instructions to staff on the level of care and treatment required for each person and included instructions on maintaining a safe environment, communication, eating and drinking, personal hygiene, toileting and continence, mobility and falls. Relatives confirmed to us that they were involved in determining and reviewing care needs of loved ones.

Staff we spoke to were able to demonstrate a good understanding of each person’s needs and the care and support required. The service was responsive to people’s needs, because we found people’s care was regularly reviewed and reflected their needs.

We observed one person becoming very agitated and aggressive towards staff at one stage during our visit in the Bluebell Court Unit. We saw staff dealt with the situation professionally, calmly and effectively whilst ensuring the safety of other people who used the service. After this person had calmed down we saw that staff continued to monitor their behaviour in a non-intrusive manner. We spoke to staff about this incident, who demonstrated a good understanding of the individual’s care and support needs. We also looked at challenging behaviour charts which were included as part of the service’s response to monitoring any changes in behaviour.

The service policy on compliments and complaints provided clear instructions on what action people needed

## Is the service responsive?

to take, which was displayed on the wall in the main reception area. We looked at the complaints file and saw all complaints had been dealt with in line with the provider's policy and in a timely manner by the provider. People told us they would not hesitate to raise issues if they had any concerns. One visiting relative told us; "If I have a serious problem I go straight to the owner's son."

Concerns were expressed about communication between families and management. Relatives were concerned that no recent resident and family meetings had taken place. One person told us; "If they have any, they always do residents' meetings during the day so they are hard to get to." "We have not had a family meeting." "There have been

no family meetings. They've never sent out a questionnaire. It would be good if they sent one out every six months or so." We looked at meeting minutes of relatives and friends meeting, which were last conducted in July 2014. Issues discussed included recruitment, training and care plans. The service used a satisfaction questionnaire for families, friends and advocates, though one had not been sent out recently. Improvements were required to ensure the service effectively engaged with relatives to ensure they were kept fully informed and updated about any developments within the home, which impacted on the care their loved ones received.



# Is the service well-led?

## Our findings

There was no registered manager in place at The Willows home when we undertook our inspection. The home had been without a permanent registered manager for over 18 months, though efforts had been made to recruit a registered manager during that period, whilst a temporary manager in post. We had undertaken several discussions with the provider during that period regarding the absence of a registered manager. We were satisfied that the provider had taken suitable steps to recruit a permanent manager during that period, though unsuccessfully. Shortly before we undertook this inspection, the provider was able to confirm that a new manager had now been appointed and was scheduled to take up their post early in 2015.

One visiting relative told us; “A new manager came and left, we don’t know why. There have been three managers since March.” Though staff we spoke to highlighted the difficulties with different managers, they all felt supported and had confidence in the provider who they felt was very flexible when it came to addressing staffing issues. One member of staff told us; “I have been provided with a lot of support by the provider recently. I feel listened to and they take on board what I say. I’m always consulted about any new changes they want to introduce. Their expectation of staff is to provide good quality care and maintain the privacy and dignity of residents.” Other comments from staff included; “He (the provider) is approachable.” “They are very open to suggestions.” “Even in the middle of the night they are accessible.” Some staff told us that they felt there had been no staff meetings recently, which provided an opportunity to be informed about developments with the service and good practice.

Both people who used the service, their families and staff were able to confirm that the provider maintained a visible

presence throughout the home and was always available to deal with any issues. One person who used the service told us; “He (the provider) pops in and we have a good chat with him.”

We found the home currently had separate Investors in People recognition for both The Willows and Blue Bell Court.

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. We found that regular reviews of care files and care plans were undertaken. We looked at monthly infection control audits that were undertaken and food hygiene inspection checklists. Audits were also undertaken of the laundry practice. We looked at cleaning schedules and weekly maintenance checks that were carried out at the home. Regular checks were undertaken of fire safety equipment including the emergency alarm and emergency lighting. Water quality and temperature checks were also undertaken. Medication audits had also been undertaken. However, improvements were required to ensure auditing processes remained effective specifically in relation to medication and recording formal written consent from people who used the service. Medication audits were limited in scope and were not effective as they did not identify any of the concerns we found during our inspection.

We found that accident and incidents were correctly recorded with corresponding entries made in individual care files detailing any action taken.

Providers are required by law to notify CQC of certain events in the service such as serious injuries and deaths. Records we looked at confirmed that CQC had received all the required notifications in a timely way from 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records
Diagnostic and screening procedures	<b>Service did not have suitable arrangements in place to maintain accurate records of people who used the service.</b>
Treatment of disease, disorder or injury	

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines
Diagnostic and screening procedures	<b>People may be at risk because the provider did not have appropriate arrangements in place to manage the safe administration of medicines</b>
Treatment of disease, disorder or injury	

**The enforcement action we took:**

CQC are currently considering its enforcement options in relation to this failure, on the part of the provider to meet the requirements of the warning notice.