ADL Plc

The Willows

Inspection report

Willow Drive
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Willows is a residential care home that provides accommodation and personal care to people aged 65 and over, some of whom maybe living with dementia. At the time of this inspection 10 people were living at the service.

People's experience of using this service and what we found
There continued to be concerns in relation to identifying and reducing risks, safeguarding people, staffing and oversight of the running of the service. A new manager had recently been employed and was committed to making changes, but enough improvement had not been made. A continued lack of oversight and support from the provider meant concerns had not been identified and progress was too slow. People remained at risk.

There were insufficient numbers of staff to meet people's needs and keep them safe. Despite the registered manager being aware of risks within the service, these had not been taken into consideration when considering staffing levels. Following our feedback after the inspection, the registered manager confirmed they had reviewed staffing levels and increased these in the afternoon. People liked the staff who provided their care, but some people told us there was not enough of them.

Internal processes to safeguard people from the risk of abuse were not followed and placed people at risk. There continued to be a lack of oversight of safeguarding matters, accidents, incidents and lessons learnt.

Some additional training had been completed by staff. However, ongoing training was still required to ensure staff had the required skills to meet people's individual needs. Staff had only recently been provided with supervisions by the new registered manager. We made a recommendation about this.

Medicines errors had reduced within the service; however, there continued to be some recording and process issues which had not been embedded in practice or identified as part of internal oversight.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. From the information we reviewed, recruitment checks were in place.

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

Rating at last inspection
The last rating for this service was Inadequate (published 5 May 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations and continues

to be rated inadequate. This is the seventh consecutive inspection that the service has been rated below good and the third to be rated inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains inadequate.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Willows on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to assessing risk and keeping people safe, safeguarding, staffing and governance.

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

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service remains 'Inadequate' and the service is therefore still in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Willows

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors attended the inspection on both days. An Expert by Experience also attended on the first day of inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Willows is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement dependent on their registration with us. The Willows is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The first day of inspection was unannounced. We told the registered manager we would be returning for the second day.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with the operations manager, registered manager, senior carer, carer, cook and cleaner. We spoke with five people who used the service. We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

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

Enough improvement had not been made at this inspection and the provider was still in breach of Regulation 12.

- Care plans and risk assessments continued to not reflect people's individual health conditions or risks associated with specific behaviour. Staff did not know about people's specific health conditions. Staff were not informed or guided on how to support people's behaviours within the home. This placed people and staff at risk of otherwise avoidable harm.
- Health and safety checks were in place. However, associated risks had not always been identified with mitigating actions. For example, we identified a significant risk to people from scolding, due to hot water. We told the registered manager to take action during the inspection to reduce this risk. We also identified risks in relation to the security of the building that had not been assessed.
- Accident and incidents were recorded. However, these had not been consistently evaluated to ensure actions were implemented to prevent similar events. Lessons learnt could not always be evidenced resulting in a reoccurrence of one incident.

The failure to assess and monitor risk was a continued breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure people were safeguarded from abuse and improper treatment. This was a continued breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of Regulation 13.

- People continued to be at risk of abuse. Care plans and risk assessments did not contain key information about people and the risks that they posed to themselves or others. We made a safeguarding referral to the

local authority safeguarding team following our inspection.
● Internal systems and process were not always followed to ensure people were safeguarded. Carers had recorded and reported incidents which had not been reviewed by the registered manager or escalated to the appropriate authorities.
● There was still no clear oversight and management of safeguarding concerns. The services safeguarding log continued to be out of date and did not reflect all safeguarding incidents which occurred within the service.

Failure to safeguard people from the risk of abuse was a continued breach of Regulation 13, (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection we recommended the provider sought advice and guidance from a reputable source, about safe recruitment process and how to assess and monitor staffing levels. The provider had not made improvements with regards to staffing levels.

● There was insufficient staff on duty to keep people safe and meet people's needs. The provider had not deployed enough staff to provide care and be available to support others and prevent people from coming to harm. There were numerous times throughout the inspection where no staff were present when people were sat in communal space. On one instance there was no staff presence in the communal lounge, leaving people unattended for long periods of time. One person told us, "No there's not enough staff, the ones that are here do too much." Following our inspection, the registered manager told us they had increased staffing in the afternoon.
● Staff had also been required to undertake other roles which meant they were not always available to monitor people. On some days there was no cook or cleaning staff, which meant staff had to undertake these tasks. This included preparing evening meals, when only two staff were on shift.

Failure to have enough staff to meet people's needs was a continued breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment checks were in place. One interview record was not available on site. However, this was provided after the inspection.

Using medicines safely

At our last inspection the provider had failed to ensure the safe administration of medicines. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12 (2)(g).

● There had been a reduction in the number of medication errors made within the service. Errors had been reported to the registered manager who had taken any action required.
● Records in relation to covert medicines and "as and when required" medicines had improved to guide staff when and how to administer these medicines.

● Some internal processes were still not embedded in practice to ensure safe practice. This included recording of stock quantities, consistency in recording the administration of medicines, and returning of medicines in a timely manner. Audits and monitoring had failed to identify or address these concerns.

Failure to have contemporaneous records and systems in place to monitor and improve practice was a continued breach of Regulation 17, (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure effective IPC measures were in place. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 12 (2)(h).

● We were somewhat assured that the provider was using PPE effectively and safely. We observed some staff wearing their mask below the nose throughout both days of the inspection. PPE had not always been disposed of correctly.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Some furniture including tables, chairs and units could not be effectively cleaned due to being damaged. Planned refurbishment had not been completed in line with the action plan previously created.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Visiting arrangements followed current government guidelines.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff received sufficient support, supervision and training. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18 (2)(a).

- The new registered manager had recently started staff supervisions. Where supervisions had not been undertaken, these were scheduled in. They had also scheduled appraisals for staff.
- The registered manager was conducting their own competency assessments on staff's skills in relation to moving and handling and medicines administration.
- The training matrix showed that staff had accessed additional training since the last inspection. However, only seven out of 15 staff on the training matrix had completed training in dementia.

We recommend the provider closely monitors the delivery of supervisions, appraisals and training, to ensure progress in this area continues.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● The registered managed had introduced systems to have oversight of DoLS applications.
● Decisions had been recorded in line with MCA principles.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● Information gathered through assessments continued to not be used to create a plan for person centred care. Initial assessments contained the most detail about people's health conditions and this had not been considered or utilised when care planning.
● Some areas of the home continued to require refurbishment. Flooring, carpets and furniture required attention. The provider had an action plan in place for refurbishment, but anticipated timescales had not been met.

Supporting people to eat and drink enough to maintain a balanced diet: Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We received mixed feedback from people regarding the food. People told us, "I don't like the dinners they get here now. There used to be four cooks who worked opposite each other but now it's all from somewhere else" and "They're [staff] always bringing drinks, mugs of tea, biscuits, we get plenty."
● People's health was not always being monitored. Monitoring charts were not always in place, and if they were, they were of poor quality. For example, fluid monitoring was not totalled, monitored or tracked and bowel monitoring was not in place for someone who required this. The registered manager told us this would be put in place.
● Records showed the home was working with health professionals when required.

Inadequate

Is the service well-led?

Our findings

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

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider was still in breach of Regulation 17.

- Following the last inspection, enough improvement had not been made and we identified continued breaches of regulation. Despite the service being in special measures from the last two inspections and the history of failing to provide good care, the provider had failed to ensure the service made the necessary improvements.
- There continued to be a lack of oversight. The newly registered manager had completed some audits, but these did not identify all the concerns we found during the inspection. There was limited evidence of provider oversight, or support, to bring the service to the standards expected to meet regulations. Following the inspection, the registered manager took some action to address the concerns raised.
- The registered manager had limited staff on site to deliver the service. During our inspection visit, the registered manager was involved in delivering direct care and communicating with professionals. This impacted on the amount of time the registered manager had to embed new ways of working and drive forward improvements.
- The quality of accurate and contemporaneous records remained poor. Records in relation to medicines administration, handovers, daily notes and monitoring charts were not detailed or sufficient.
- Internal processes were not always followed which would drive forward improvements. This included medicines process and the providers own refurbishment action plan not being met.

Failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; How the provider understands and acts on the

duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager had not always submitted notifications about incidents as they are required to do by law. The providers lack of oversight meant this had not been identified.

Failure to notify CQC as required was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. This is being followed up outside of the inspection process and we will report on any action once it is complete.

● People did not receive person-centred care focused on outcomes. The service needed much improvement to ensure people were empowered to achieve good outcomes.

● People, Relatives and staff were consulted on their opinions of the service. Although this information was collated, no action had been taken in response to the feedback. When suggestions were given, these were not always acted on in a timely manner. One person told us they had raised a suggestion at a residents meeting; "I know I suggested they fix a handrail to the ramp into the garden, it's only a slight slope but when you use a walker you feel a bit unsteady, but I don't know if anything will happen." We checked the minutes of the meeting which confirmed this suggestion was made, but no action had been taken at the time of the inspection to put this in place.