Angel Plus Homes Ltd

Willowbank Rest Home

Inspection report

42 Lancaster Lane
Clayton-le-Woods
Leyland
Lancashire
PR25 5SP

Tel: 01772435429

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection was unannounced, which meant the provider did not know we were coming. It was conducted on 10 April 2017.

Willowbank Rest Home is registered to provide care and accommodation for up to 19 adults. The home is situated on the outskirts of Leyland in a quiet residential area and is within easy reach of Preston and Chorley. All accommodation is provided on a single room basis and there are a variety of communal areas for residents' use. Bathrooms are located throughout the home. A range of amenities are available in the area and public transport links are nearby. There are ample car parking spaces adjacent to the premises.

At our last inspection on 17 March 2016 we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person centred care, dignity and respect, the premises, infection control, medicines management, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs and good governance The provider submitted a detailed action plan to show that all areas requiring improvement would be completed by 28 August 2016.

During this inspection we consulted the provider's action plan and found that substantial improvements had been made since our previous inspection. We found that regulations 9, 10, 12, 13, 14 and 17 were no longer in breach, in relation to continuous shortfalls. However, we did identify other areas that were in need of attention. We found that the provider had not always safeguarded service users from abuse and improper treatment, because they had failed to report a serious incident of alleged abuse on behalf of a service user. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not always obtained formal consent in relation to the provision of care and treatment. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A more detailed description of the breaches is contained within each relevant section of this report.

Although the nutritional plan of care for one person was very detailed in relation to choking risks, a separate risk assessment had not been developed on this occasion. We made a recommendation about this.

We observed that the dietary intake charts did not record any snacks taken during the day or night and some fluid balance charts had not been totalled. Therefore, it was not easy to determine if people were receiving sufficient fluid intake. We made a recommendation about this.

Personal Emergency Evacuation Plans [PEEPs} were in place for those who lived at Willowbank. However, not all relevant information was always recorded to support a safe evacuation, should this be required. We made a recommendation about this.

Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings and complaints were managed well. The provider had forwarded the required notifications to

CQC, as and when required. However, the management of safeguarding incidents had not been well managed, as an allegation of abuse had not been appropriately reported. We made a recommendation about this.

People who lived at Willowbank told us they felt safe being there and we found that the recruitment practices were robust, which helped to protect people from harm. There were sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home.

We noted that people were supported to mobilise, when help was needed and freedom of movement was evident within the home. We observed that call bells were answered in a timely manner.

The staff team were well supported by the management of the home, through the provision of information, induction programmes, supervision, appraisals and training modules. The staff members we spoke with had a good understanding of people in their care and were able to discuss their needs well.

Interaction by staff with those who lived at the home was positive. Staff members provided good, sensitive and caring approaches. People were treated with kindness and compassion. Their privacy and dignity was consistently promoted.

A wide range of community professionals were involved in the care and treatment of those who lived at the home. This helped to ensure that people's health and social care needs were being appropriately met.

We found that detailed social care profiles contained some good information and these reflected peoples' preferences and what they liked to do. Information in relation to allergies would have been better placed at the front of the care records, in order to make it more prominent and easily accessible, should it be needed in an emergency situation.

Activities were being provided during our inspection and good humoured interaction took place between staff and those who lived at Willowbank.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to need for consent and Safeguarding service users from abuse and improper treatment.

You can see what action we told the provider to take at the back of the full version of this report.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

This service was not consistently safe.

People who lived at Willowbank told us they felt safe. However, the PEEPs records did not always contain all relevant information.

We found recruitment practices to be robust. There were sufficient staff on duty on the day of our inspection and it was observed that staff were always present in the communal areas of the home.

The management of medicines was, in general satisfactory. We found that an allegation of abuse against a service user had not been appropriately reported.

We noted that people were supported to mobilise, when help was needed and freedom of movement was evident within the home. We observed that call bells were answered in a timely manner.

Is the service effective?

Requires Improvement

This service was not consistently effective.

Care plans reflected people's assessed needs well.

Meals were nutritious and well balanced. People were supported with their meals in a sensitive manner.

Deprivation of Liberty Safeguard (DoLS) applications had been made, as needed and Mental Capacity Assessments had been conducted, as appropriate.

Consent forms were present in the care files we saw. However, these had sometimes been signed by a family member, but no evidence was available to demonstrate that they had legal authority to provide consent on behalf of their relative.

The staff team were well supported by the management of the home, through the provision of information, induction programmes, supervision, appraisals and training modules. Staff

we spoke with had a good understanding of people in their care and were able to discuss their needs well.

Is the service caring?

Good

This service was caring.

Interaction by staff with those who lived at the home was positive. Staff provided good, sensitive and caring approaches, which respected people in their care.

People's privacy and dignity was consistently promoted by the practices adopted by the home and their wishes were respected.

Some bedrooms were individualised, containing personal items and sentimental mementos

A wide range of community professionals were involved in the care and treatment of those who lived at the home. This helped to ensure that people's health and social care needs were being appropriately met.

Is the service responsive?

Good

This service was responsive.

During our inspection we 'pathway' tracked the care of four people who lived at the home. Social care profiles were in place in each person's care file, which reflected peoples' preferences and what they liked to do. Needs assessments had also been conducted before people moved in to the home and plans of care were person centred.

We found that significant improvements had been made in planning people's care.

Activities were being provided during our inspection and good humoured interaction took place between staff and those who lived at Willowbank.

Complaints were being well managed.

Is the service well-led?

Requires Improvement

This service was not consistently well-led.

Records showed that people's views about the quality of service provided were sought in the form of surveys and meetings.

The system for assessing and monitoring the quality and safety of the service provided had improved, by the introduction of audits and provider's reports. This enabled shortfalls to be identified and improvements to be made. However, the systems in place had not identified one allegation of abuse.	

Willowbank Rest 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This unannounced inspection was carried out on 10 April 2017 by two Adult Social Care inspectors from the Care Quality Commission (CQC). We were accompanied by an expert by experience. An expert by experience is a person who has had some experience of the type of service being inspected or has been involved in caring for someone within this particular client group. Our expert had cared for someone living with dementia.

At the time of our inspection of this location there were 16 people who lived at Willowbank. We were able to speak with eight of them and two relatives. We also spoke with four staff members, who had worked at Willowbank for varying lengths of time and the registered manager of the home.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the care files of four people who used the service and the personnel records of two staff members.

We 'pathway tracked' the care of four people who lived at the home. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

The provider completed and submitted a Provider Information Return (PIR) within the time frames requested. A PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents,

injuries and deaths. We were in regular discussion with local commissioners and community professionals about the service provided at Willowbank.

Requires Improvement

Is the service safe?

Our findings

People we spoke with, in general said they felt safe living at Willowbank. One person told us, "Yes [feeling safe], because everybody's [staff] so with it, so honest and they keep you in the picture." Another person said, "Staff lock the main door at night. People who live here are harmless." However, the following comments were also received, which we recommend are followed up by the provider: "I have a key for the lock on my bedroom door. I lock the door [the person accesses the community], come back and the door is unlocked. Staff say they can't lock every door." And, "Yes [feeling safe], up to a point. I get disturbed at night. Two people wander about and bang on doors at night."

We asked people if they felt there were enough staff on duty. Their comments included, "Oh yes, there's enough. They're on the mark. I haven't needed to ring the buzzer"; "There's plenty of staff. They are very good, very pleasant and friendly. They will do anything you ask." And, "There's enough staff. They will come when I need them."

People we spoke with felt that staff were competent to do their jobs. One person commented, "I think they cope with everything on the whole very well." Another told us, "If you want help with anything they're very pleasant. Even the night staff are all nice too."

Staff members we spoke with told us they had undergone training in relation to safeguarding adults and records we saw confirmed this information to be accurate. They were also fully aware of the whistleblowing policies and were confident in reporting any concerns in the most appropriate way. Staff members we spoke with gave us some good examples of when a safeguarding referral needed to me made. However, there was one incident, which we noted had not been reported under safeguarding procedures and which should have been. We asked the registered manager to make a safeguarding referral on the day of our inspection.

We found that the provider had not always safeguarded service users from abuse and improper treatment, because they had failed to report a serious incident of alleged abuse on behalf of a service user. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider subsequently informed us that lessons had been learnt from this failure and that action had been taken to ensure this situation did not reoccur.

At our last inspection on 17 March 2016 we found several areas which did not promote people's safety. The provider had not always ensured the premises were safe to use for their intended purpose and risks associated with infection control had not been properly assessed. We also found that medicines were not being well managed at that time.

At this inspection we found that some environmental improvements had been made in relation to safety, maintenance and cleanliness. The provider had developed a cleaning schedule and a refurbishment programme for the entire building, which encompassed some of the areas we identified as needing improvement. This was in progress and therefore improvements were on-going. However, we did note some areas that needed attention, in order to promote an enhanced environment for those who lived at the

home. We made a recommendation about this. At this inspection we found that a significant improvement had been made in relation to the management of medicines. Therefore, the breach of regulation 12 was met on this occasion.

We looked at how environmental safety was being managed. We saw documentation, which showed that a range of environmental risk assessments had been conducted. These covered areas, such as hot water temperatures, maintenance work, external grounds, equipment and internal environment. We tested the temperature of hot water being supplied in several locations, selected at random throughout the home and found it to be at safe temperatures at the time of this inspection. We noted that the window restrictors had been replaced throughout the building, in order to promote people's safety.

The passenger lift was out of order. We were told that this had not been operational for over a year. However, a stair lift had been installed for people to transfer between floors. The care records we saw of those who needed to use the stair lift contained relevant risk assessments and we saw confirmation that the stair lift had been appropriately serviced. This helped to make sure that people's safety was maintained whilst using the stair lift.

During our inspection we assessed the management of medicines. We found these to be in general satisfactory. However, there were two areas, which could have been better. For example, the application of topical creams and transdermal patches could have been more robust, with the implementation of specific treatment charts, as well as the Medication Administration Records [MARs] already in place. This would provide a clear audit trail for the administration of creams and patches. This could be added to the home's medication policies and procedures. Protocols for the administration of 'as and when required' [PRN] medications would help to ensure that staff were aware of when to administer such medicines. These two areas were discussed with the registered manager at the time of our inspection, who agreed that the implementation of specific treatment charts and PRN protocols would be beneficial and that these would be implemented without delay.

People we spoke with, who lived at the home were satisfied with how their medicines were managed. One person told us, "I get it [medication] twice a day and take it myself. If I need a paracetamol I get a paracetamol." Another commented, "They know all about my medication". And a third said, "I've just taken my medication. They bring it to me on time."

We overheard a care worker ask one person at lunch time, "[Resident's first name] would you like some paracetamol?" The person answered, "Yes please." The carer then established if the person wanted one or two paracetamol. She then added, "I'll change your patch [for pain relief] at six." This individual then told us, "They're very good at that. They always remember [to change the analgesic patch]."

We noted a calm atmosphere to be evident throughout our inspection. People who lived at Willowbank were able to move around the home freely and were supported by staff members, when help was needed.

We noted that staff members were always present within communal areas of the home and that call bells were answered in a timely manner. There were sufficient staff on duty to meet the needs of those who lived at the home and staff members we spoke with felt that there were enough staff deployed on each shift.

During the course of our inspection we looked at the personnel records of two people who worked at Willowbank. We found that recruitment practices adopted by the home were robust, which helped to keep people safe. Each staff members' file contained two written references and Disclosure and Barring Service (DBS) checks. DBS checks highlight if the prospective employee has received any criminal convictions or

cautions. This helps the provider to decide if the individual is deemed fit to work with the vulnerable people, who live at the home. Each applicant completed health questionnaires and application forms. Those who fit the criteria for employment were then interviewed, when any gaps in employment were further explored.

Accident records were completed appropriately and were retained in accordance with data protection, so that personal information was kept in a confidential manner. Records showed that systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations. This helped to ensure they were safe for use.

During our inspection we toured the premises. We found that some enhancements had been made to the environment, in relation to safety, maintenance and cleanliness. However, we found other areas, which were in need of improvement. For example, the floor covering in some bedrooms was inadequate and the flooring in one bedroom was uneven. The curtains in some bedrooms were off the curtain rail and a curtain rail in one bedroom was insecure. One radiator cover was found to be loose and there was no hot water sign above the wash hand basin in a toilet facility. The double glazing seal had blown in the window of one bathroom.

The stairwell was easily accessible from the ground floor and the first floor. However, shortly after the inspection the provider confirmed in writing that the ground floor doors had been fitted with coded magnetic locks, in order to reduce the risk of unsupervised access to the stairs leading to the first floor, and therefore reduce the risk of potential injury, due to falls. There was no key pad in place on the front door, but a mechanism, which could easily be operated, allowing easy access to the car park and surrounding area.

The clinical waste bin in one bathroom was rusted and in need of replacing and there were six unclean commodes stacked up in the first floor bathroom. One bathroom was in need of cleaning and the radiator was dirty under the cover. Several air vents were dirty and in need of cleaning. The sink unit in one bedroom was warped and the over-bed table had part of the edging missing. There were several beds, which had been made up on the morning of our inspection, which had dirty, torn or stained bottom sheets. One had a duvet cover being used as a top sheet. One sensor mat was dirty and some ceiling tiles in one bedroom were stained.

We noted that a cleaning schedule was in place and a refurbishment programme had been developed, which encompassed some of the areas we identified as needing improvement. Letters to families were seen on care files, in relation to the planned refurbishment of the home. One person we spoke with commented, "The place could do with modernising a bit more. How to do it I don't know." We recommend that the refurbishment programme be adhered to, as planned, so that improvements are made to the premises, in order to enhance the environment for those who live at the home.

Fire prevention policies were in place and these were prominently displayed within the home. A fire risk assessment had been developed and individual Personal Emergency Evacuation Plans (PEEPS) had been implemented for each person who used the service, although two we saw had not been dated and one did not include the size of the hoist sling that would be needed for evacuation purposes. The PEEPS were retained in a separate folder in the main central office, so that if evacuation was needed the emergency services had sufficient information to assist people to vacate the premises in the most appropriate way. It is recommended that all relevant information be added to these records in order to promote a safe evacuation, should this be needed.

The care records we saw contained a wide range of risk assessments around people's health care needs, such as potential risks related to moving and handling, bed rails, medicines, communication, behaviours,

falls, nutrition and tissue viability. However, there was just one bed rail risk assessment, which had not been reviewed, since it had been developed in October 2016.

Records we saw demonstrated that people were monitored, as required. For example, in relation to weight loss or risk of falling. We noted that appropriate action had been undertaken as a result of assessments identifying a level of risk. This helped to ensure people were protected from harm. However, we pathway tracked the care of one person, who was at risk of choking, due to swallowing difficulties. Although the nutritional plan for this person was very well written, incorporating identified risk factors and appropriate specialist health care intervention had been sought, a separate risk assessment for choking had not been implemented. It is recommended that a separate assessment be implemented for this area of potential risk and all risk assessments be reviewed at regular intervals, or more often, if need be.

Requires Improvement

Is the service effective?

Our findings

People we spoke with felt that the food served was, in general satisfactory. Comments we received in relation to the meals included, "Very good [the food]"; "The meals are quite good. There's plenty of tea, coffee, biscuits and cake throughout the day"; "The food's alright here. We have drinks during day." Also, "The dining experience is formal like any dining room. It is clean and tidy, but quiet". One person told us that they ate their meals, where they preferred to do so and this was usually in a small lounge, rather than in the dining room. Another person told us, that their dietary preferences were respected by the staff team. They commented, "I don't eat chocolate or drink coffee. So they [the staff] don't give it to me".

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw people being asked verbally for their consent before care and support was delivered. The care records we saw contained consent forms for the administration of medicines, consent to care and treatment and the taking of photographs, although there was no evidence available to show that consent had been obtained for the use of bedrails. One person who used the service had signed their own consent forms. However, in several instances the consent forms had been signed by a family member, but there was no evidence available to demonstrate that the person signing the form had legal authority to provide consent for their relative, as Lasting Power of Attorney. Neither was there a record of meetings being held around best interest decisions for the individuals concerned.

We found that the provider had not always obtained consent from the individual concerned or their legal representative, in relation to the provision of care and treatment, such as the use of bed rails. This was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 17 March 2016 we found that the provider had not always ensured that lawful authority had been granted in order to deprive someone of their liberty.

At this inspection we found that the registered manager had applied for Deprivation of Liberty Safeguards (DoLS) based on people lacking capacity, not being free to leave the home alone and being continually under supervision. This included the use of sensor mats and door alarms. Most of the care files we saw

contained copies of standard DoLS authorisations, where appropriate. The new registered manager had conducted and updated Mental Capacity Assessments for all those who lived at the home and who potentially lacked the capacity to make specific decisions. Therefore, the breach of regulation 13 was met on this occasion.

At our last inspection on 17 March 2016 we found that the provider had not always ensured that people's nutritional needs were being fully met.

At this inspection we found that people were receiving a nutritious and well balanced diet and meal times were being well managed, with good support being offered. Therefore, the breach of regulation 14 was met on this occasion.

We noted that the menu offered a choice of meals and a variety of dishes were available. The menu was also displayed in a pictorial format, for easy recognition by those who were living with dementia, or those who had difficulty reading the standard menu. This allowed everyone the same opportunities, in relation to meal choices. Three meals were provided each day, plus supper and snacks in-between meals, as was needed. People were asked their dietary preferences from the menu, but were able to have alternatives, if they wished to do so.

One of the inspectors assessed the management of meals and sampled the food served at lunch time. A member of staff told us that people were assisted into the dining room approximately ten minutes before their meals were served, but that staff checked with the chef first to ensure the meals were on schedule. This avoided people sitting at the dining tables for long periods of time.

The dining experience was pleasant. The dining tables were covered with white cloths and aprons were offered to people, should they wish to protect their clothing. There was a good ratio of staff to people eating in the dining room. This helped to ensure they received appropriate support. People were offered a choice of cold beverages at the beginning of their lunch and again part way through. The meals were nutritious, tasty and well balanced. People were seen to be enjoying their food.
We saw several examples of good interactions by staff at meal times. One person was sitting at a dining table, who needed support from a staff member with their lunch. The care worker sat at the dining table with the individual and assisted them in a patient and respectful manner, whilst chatting with the resident and the other people sitting at the same dining table.

We saw one person at lunch time, who required additional support and observation, due to intermittent coughing spasms. Care workers managed the situation well by ensuring the individual did not come to any harm and by offering them an alternative meal, which was accepted and eaten without any difficulty.

We observed staff members offering people hot beverages and biscuits during the afternoon. The care staff knew people well. A member of the staff team asked one person, who was hard of hearing several times what they would like to drink. This was done in a patient and good humoured way, which helped the individual to feel less embarrassed, due to their disability.

We noted staff to be attentive to peoples' dietary needs, encouraging and praising them in a supportive manner. They worked well as a team, demonstrating an efficient, but unrushed approach.

We observed that the dietary intake charts did not record any snacks taken during the day or night and some fluid balance charts had not been totalled. Therefore, it was not easy to determine if people were receiving sufficient fluid intake. It is recommended that all snacks are recorded on the dietary intake charts

in use and that fluid balance charts are totalled at the end of each shift, so that any shortfall in fluid intake can be reported promptly and addressed appropriately.

The menu provided people with a wide selection of nutritious and well balanced meals. A full English breakfast was available each morning, should people choose it. A choices of three meals were offered at lunch time, although different options were also available, should someone wish to have an alternative. We saw one person had been served with a variety of finger foods and was evidently enjoying this type of snack. People we spoke with, who lived at the home told us that they were satisfied with the quality of food served.

We established that new employees were issued with a range of information when they first started to work at the home, such as the employee handbook, Job descriptions and terms and conditions of employment. These informed them of what was expected of them whilst working at the home and outlined their duties specific to their individual roles.

Records showed that a detailed induction programme was provided for all new staff, which was in line with the nationally recognised care certificate. Modules covered during this initial training included, values, confidentiality, person centred approach, risk assessing, moving and handling, health and safety, fire awareness, first aid, infection control, safeguarding adults and medication management. This helped new employees to gain some knowledge around important areas of care and to prepare them for their specific roles at Willowbank.

The probationary period for new employees lasted for a period of three months, although this could be extended, if needed. This was followed by a performance review, which identified areas for development, with key actions being agreed. This enabled new staff members to decide if they wished to continue to work at the home and allowed managers to determine the suitability of each employee.

Staff members we spoke with felt well supported by the registered manager of the home and records showed that a wide range of training was provided, which was suitable for individual roles. One member of staff we spoke with, who had worked at Willowbank for six months, told us that they had been supported through their detailed induction programme by the manager of the home. This employee also told us that they had completed all the online training, which was mandatory. They gave some good examples of learning modules they had accomplished, such as safeguarding adults, infection control, fire awareness, moving and handling and whistle-blowing. They confirmed that some of these courses also included practical sessions, such as moving and handling.

One staff member told us that they received monthly supervision sessions from the registered manager of the home and that they felt very much supported by the management team at Willowbank. They said, "I am extremely happy working at Willowbank. I don't have any concerns at all." Staff personnel records we saw showed that supervision sessions were held regularly and annual appraisals were conducted. This allowed staff members to discuss any areas of concern with their line manager. It also helped them to improve their work performance and focus on their personal development.

During our tour of the premises we noted that the provider had supplied equipment necessary, so that people's comfort and dignity was promoted, such as specialised mattresses, profile beds and mobility aids. We also noted that the toilet seats were raised and in contrasting colours from the toilet bowl. This helped those who lived with dementia to recognise the toilets more easily.

Good

Is the service caring?

Our findings

People we spoke with felt that staff had a kind and caring approach. Comments we received included, "Staff are caring. If I had a problem I'd talk to them and get some advice"; "The staff are definitely caring. All of them-Day and night"; "They're good caring staff. I can't deny that"; "The staff are perfect. We have fun together especially [name removed – a carer), she's perfect"; "Staff are respectful"; "I have a commode. I tell them when to empty it. No problems at all"; "I'm mostly independent. I need help with some things. That's why I'm here"; "Staff will listen to me"; "It's a smashing place this"; "I can go out of home. I just tell them [the staff] where I'm going and I go." And, "I do my own ironing. Staff respect my wishes."

One person, who was on respite care told us that they were enjoying their time at Willowbank, particularly the social activities and that they would be sad to leave. We observed some good interactions by staff during our inspection. For example, a care worker told one person, "[Name removed] that's your frame. Are you going down for something to eat?" and then very discreetly asked, "Do you need the toilet before lunch?" The carer then pointed out the nearby toilet door and added, "I'll watch for you coming out."

At our last inspection on 17 March 2016 we found that the provider had not always ensured that people were treated with dignity and respect.

At this inspection we found that people were treated in a kind and caring manner, with their privacy and dignity being respected. Therefore, the breach of regulation 10 was met on this occasion.

We saw one care worker bring a person into the lounge in a wheelchair. The carer asked where the individual would like to sit, then safely and unrushed transferred the person to the lounge chair of their choice, chatting with them in a reassuring and caring manner. The carer then provided a footstool and cushion to support their legs.

We observed one person alone in the dining room. They held a small teddy bear. Several staff repeatedly came to check on the individual, to ensure they were safe and happy. Each one spent time with the person. One staff member asked if they wanted a cup of tea, which was provided immediately. On the dining table was an activity cloth with different textures and materials, and an activity frame with different moveable objects. A plate of finger foods and sweets had been provided for this individual. There was a radio gently playing in the background. The resident seemed to be very content and happy. We saw one person starting to enter another resident's bedroom. An ancillary staff member saw him, explained that it was the wrong room and gently escorted him into his adjacent bedroom. This was done in a kind and caring manner, allowing the person time to readjust to the situation.

Our observations in relation to staff interacting with those who lived at the home were positive. We saw some good, sensitive and caring interactions between care workers and those who lived at the home, with people's privacy and dignity being consistently respected. We observed people being able to express their views, which were listened to and acted upon by staff members.

A key worker system had been introduced. This helped to ensure that people developed a good, trusting relationship with staff members and that they received the care and support they needed. People who lived at the home looked comfortable in the presence of staff members and everyone we spoke with said they felt able to talk to any member of the staff team.

One care file we saw contained a record of the specific wishes of the individual in relation to end of life care and their decisions around resuscitation. The 'Do Not Attempt Cardio Pulmonary Resuscitation [DNACPR]' record had been signed by the GP following a discussion with the individual concerned. A second care file clearly read, 'Please resuscitate me.' This was the wishes of the individual concerned and this decision had been discussed with them.

Records showed that a range of community health care professionals were involved in the care and treatment of those who lived at Willowbank, such as GP's, district nurses, dieticians, opticians, Speech and Language Therapists [SALT] and Mental Health Teams [MHT]. We saw that urgent services, such as 111 were contacted for advice, as was required and Multi-Disciplinary Team [MDT] meetings were held to discuss the care and treatment of people who lived at Willowbank. This helped to ensure that people received the health care they needed.

The care records we examined incorporated the need for privacy, dignity and independence, particularly during the provision of personal care and spiritual activity. During our tour of the premises it was clear that some people had their own bedroom door keys. This helped to protect people's personal belongings and to promote independence and privacy. We saw that staff supervision sessions covered dignity in care, which helped the staff team to promote privacy and dignity for those who lived at Willowbank.

We saw some bedrooms were personalised with pictures, ornaments and furniture belonging to the individual, which was pleasing to see. We saw those who lived at the home to be well presented and they looked happy in their environment. One member of staff told us, "I love these residents. I love to chat with them."

Good

Is the service responsive?

Our findings

People we spoke with felt that the staff team was responsive to their needs and person centred care was provided. They did not feel restricted in any way. One person told us, "I use my walking frame to get around myself. There are no problems here."

In relation to activities one person said, "Not a lot goes on, but you get invited to join in and it's up to you if you don't." Another told us, "We play games. It's like going back to your childhood [this was said in a positive manner]. The activity coordinator is lovely." And a third commented, "I go out [to see people] and I watch TV. There's nothing for men to do, like darts. People are asleep. I get fed up with the same programmes on TV. They do play games, but I don't want to get involved."

One person told us that a good pair of trousers had been lost and they were never found. This individual told us that the manager did apologise, but that they never received a replacement.

The monthly activity plan was clearly displayed within the home. An activities coordinator was employed, who we saw provided some interesting activities for those who lived at Willowbank. The majority of people we spoke with expressed their satisfaction about the activities provided at the home. We saw that a variety of tactile activity items were available around the home and we observed one person making use of these objects.

We established that the activities coordinator was an experienced member of staff. We spoke with her and it was clear that she was very committed to Willowbank and the people who lived there. She told us that she arrived for duty early each day, so that she could help with assisting people back to the lounge following breakfast and so that she could speak with people individually, in order to determine their wishes for the activities of the day or in the future. We were told that care staff also provided some activities at weekend, but that if there was any special event during this time, then the activity coordinator attended the home.

The activity coordinator told us, "The residents like quizzes and music. We do crafts on an individual basis. I get around most people every day." We saw this member of staff cutting one person's fingernails. The individual said, "It's nice to be looked after." The activity coordinator told us, "I asked [name removed] last week if they wanted their nails cutting, but they were not feeling 100%, so we left it and I said just let me know when you want them cutting, so they asked me this morning to do them today." When the manicure had been completed, the person said, "I'm very grateful."

A one off activity was sometimes provided, in accordance with people's wishes. For example, one person, who lived at the home, had expressed a wish to make something, such as a card for a staff member, who was soon to be married. Another wanted to make a poetry book, containing the staff member's favourite poems to celebrate the occasion. These people were supported to achieve their goals. The activity coordinator had recorded a documentary from the television about memory and reminiscing old photographs. This was used to promote discussions with people and proved to be an enjoyable activity.

One person was being cared for in bed. They were unable to communicate verbally and were totally dependent on staff intervention. We saw a member of staff reading to them in a very caring way.

Two visitors arrived during the afternoon to play dominoes with their friend, who lived at Willowbank. They were served beverages and made to feel very welcome to the home. One of the visitors told us, "The staff are very caring in how they treat the residents."

We saw one person completing a jig saw with a member of staff and a variety of floor games were being enjoyed in the lounge area. There were ongoing discussions about the recent Grand National and Masters-Golf tournament, as well as plans for Easter activities.

At our last inspection on 17 March 2016 we found that the registered person had not always ensured an assessment of needs and preferences for care and treatment had been conducted and plans of care had not been designed to reflect individual requirements.

At this inspection we found that people's needs had been assessed prior to a placement at the home being arranged and individual preferences had, in most cases been considered. There had also been significant improvements in the planning of people's care. Therefore, the breach of regulation 9 was met on this occasion.

During the course of our inspection we 'pathway' tracked the care of four people who lived at Willowbank Rest Home. We found that photographs of individuals were not always present on the care records we saw. This would help to identify people more easily, should they become a missing person. Pre-admission and dependency assessments had been conducted before a placement at the home was arranged. These incorporated people's health and social care needs. Information from other community professionals had also been sought; this helped to ensure that the staff team were confident they could deliver the care and support required by each individual who was planning to move into Willowbank.

We found that, in most cases detailed social care profiles contained some good information and these reflected peoples' preferences and what they liked to do. Medical histories were clearly recorded and prescribed medication documented accurately. However, we noted that information, in relation to any allergies was alongside the plan of care for breathing. This perhaps may be better placed at the front of the care files, so that it is more prominent and easily accessible in the case of an emergency situation.

We noted significant improvements with the planning of people's care since our last inspection. Some excellent care plans had been developed, which were person centred and which provided the staff team with clear guidance about the needs of people and how these needs were to be best met. For example, the plan of care for one person who lived at the home provided a very good explanation of when the individual's behaviour escalated and how this was to be managed. However, the plan of care in relation to mobility could have provided more detailed information, such as the size of hoist sling to be used. The care plan, in relation to nutrition was very well written and described clearly the specific dietary needs of this individual. The plans of care had been reviewed each month, or more often, should this be necessary and any changes in need had been recorded well. There was no evidence available to demonstrate that people had been involved in planning their own care or that of their loved one. However, the plans of care we saw were in the main very person centred and contained detailed, specific information about individuals who lived at Willowbank. Care staff members had signed to indicate that they had read and understood the contents of each person's care plan.

We noted that a complaints procedure was in place at Willowbank and a system was in place for the

recording of complaints received by the home. We found that complaints were being well managed, although the letters of response to complainants were not always retained with the complaints log.

Requires Improvement

Is the service well-led?

Our findings

We asked people who lived at the home if they knew who the registered manager was. One person said, "Yes. I talk to the Registered Manager." Another told us, "If I've anything on my mind, I can go to her for advice."

Other comments we received about the home included, "It's a very nice place here. I've got plenty of friends here"; "It's very friendly"; and "Family are made to feel welcome. They [the home] want your family to come and visit." We were also told, "They're [visitors] made welcome by staff."

The registered manager had been in post at Willowbank for a period of nine months. She was very co-operative and helpful throughout the inspection process. During this inspection we observed a positive culture, which enhanced the quality of service provided. Staff we spoke with provided us with positive feedback about the management of the home. One member of staff commented, "The manager is very supportive; one of the best managers I have had."

A wide range of policies and procedures were in place at the home. These included areas, such as safeguarding adults, privacy and dignity, health and safety, infection control, fire awareness, complaints and the Mental Capacity Act and Deprivation of Liberty Safeguards. This helped to ensure that the staff team were kept up to date with current legislation and good practice guidelines. The home had achieved an external quality award, which showed that a professional organisation had assessed the quality of service provided.

At our last inspection on 17 March 2016 we found that the provider had not always maintained securely an accurate record in respect of each service user. Neither had the provider established effective systems to assess and monitor the quality of service provided, in order to mitigate risks relating to the health, safety and welfare of those who lived at the home and others who used the premises.

At this inspection we found that records relating to those who lived at the home were stored securely and that the provider had introduced a more robust system, in order to assess, monitor and improve the quality of service provided which helped to mitigate any potential risks and therefore promoted people's safety. Therefore, the breach of regulation 17 was met on this occasion.

We were shown some internal audits, which covered areas, such as incidents and accidents, nutrition and hydration and infection control. Action plans were drawn up following these audits. This helped to ensure that areas for improvement were identified and addressed in a timely manner. However, the systems in place failed to identify that a safeguarding incident had not been appropriately reported. It is recommended that the audit processes incorporate a full assessment of safeguarding incidents, to help ensure these are dealt with in an appropriate manner.

We noted that there was a good retention of staff, with a number having worked at Willowbank for several years. This helped to provide continuity of care. Staff we spoke with had a good understanding of their roles

and responsibilities towards those who lived at Willowbank.

Records showed that residents and relatives meetings were held regularly. This allowed people the opportunity to discuss various topics in an open forum, should they wish to do so. The minutes of these meetings showed that people who lived at Willowbank and their relatives had been involved in discussions relating to refurbishment, meals and future activities and changes had been made in accordance with suggestions made by those who lived at the home.

A range of regular meetings were also held for the varied disciplines of the staff team, so that any important information could be disseminated throughout the workforce. This enabled those who worked at the home to discuss any relevant topics and to keep up to date with any specific changes in legislation or good practice guidelines.

We saw that surveys for those who lived at the home, their relatives, staff and stakeholder in the community had been conducted this year. We noted that a survey had recently been circulated to those who lived at the home, in relation to the quality of food served. The responses received were positive. This helped the management team to seek people's views about the quality of service provided.

The provider had displayed the home's previous CQC rating within the home and on their website. The provider had forwarded the required notifications to CQC, as and when required. Copies of these were also retained on site for easy reference. Accidents and incidents were documented appropriately and these records were retained in line with data protection guidelines.

Records showed that the provider produced reports following some of his visits to the home, which showed that he spoke with the majority of those who lived at the home, in order to obtain their feedback about the services provided at Willowbank. The reports we saw contained positive comments made by those who lived at the home. The provider's reports also demonstrated that he made observations around safety, consent, communication, activities, moving and handling and respect and dignity.

We saw a recent online survey, which had been conducted and in which a good number of people had participated. All responses we saw were positive, with answers selected for each topic as 'good' or 'excellent'.

We were told that the provider was very supportive and visited the home several times each week, but that he was always available by telephone, should the need arise. One member of staff told us, "The owner is very approachable. He always asks if we have any concerns or worries." Staff morale at the home was described by one staff member as, 'Amazing'. One member of staff commented, "I like being here." Another told us, "I love it at Willowbank. I have no concerns." And a third said, "It's a good team. The staff morale is good. All the staff get on. We work brilliantly as a team."

The provider attended the home during our inspection. We discussed the future plans for Willowbank and we were told of the company's intentions to make improvements to the environment. We observed the provider walking around the premises, speaking with people in their private accommodation and the communal areas of the home. This was done in a respectful manner, which was pleasing to see.

We saw the provider speaking with one person and their visiting son. The individual thought the provider was a doctor. His son told him it was the owner of Willowbank. The provider then said to the resident, "It's your home. I look after your home."

We spoke with two visitors during the course of our inspection. One of them, who had been visiting for several years, told us, "I'm very happy. The staff are brilliant. Sometimes it's fantastic, because my relative is happy. All the family are quite happy with what goes on here." The other visitor, who was a local church minister commented, "Since the new owner came, the service has certainly improved. It is certainly brighter and cleaner. They [the staff] seem to be doing their best for residents, as far as I can see. It's definitely on the up. The owner is very pleasant and is willing to listen. He is positive about us resuming religious services. These were stopped by a previous owner. It is a very pleasant atmosphere."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent We found that the provider had not always obtained consent from the individual concerned or their legal representative, in relation to the provision of care and treatment, such as the use of bed rails.

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 We found that the provider had not always safeguarded service users from abuse and improper treatment, because they had failed to report an incident of alleged abuse against a service user.