Cotswold Spa Retirement Hotels Limited

Willow Court Care Home

Inspection report

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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

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service

The inspection was carried out over two days. We visited the service unannounced on 29 July 2014 with two inspectors, an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. Two inspectors visited the home announced on the 4 August 2014.

The service met all of the regulations we inspected at our last inspection on 13 February 2014.

Willow Court Care Home provides accommodation and personal care for up to 48 people, some of whom have mental health needs or are living with dementia. There were 43 people living at the home on the days of our inspection.

Summary of findings

A registered manager was in post. She was due to leave at the end of August 2014. 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; as does the provider.

We spoke with a local authority contracts and monitoring officer prior to our visit. She told us that the local authority had placed a suspension on admissions at Willow Court because of previous safeguarding concerns which dated back to May 2013. This related to people who were funded by the local authority. She said that the suspension had been partially lifted recently to allow the home to admit two new people a month. The partial suspension on admissions was to make sure that staff had the necessary resources to meet people's needs.

We spoke with staff who were knowledgeable about what actions they would take if abuse was suspected. They told us that they had not witnessed anything which concerned them. However, we were contacted by the local authority safeguarding team prior to our inspection to inform us there had been a delay in taking appropriate action following a recent safeguarding incident. During our inspection we read that there had been an altercation between two people which had not been reported to the local authority safeguarding team or the Care Quality Commission.

We observed that not all areas of the home were clean. There was a smell of stale urine in the corridors and also in some of the bedrooms we checked.

We had concerns with certain aspects of medicines management such as the recording and storage of medicines.

We found that the service was meeting the requirements outlined in the Deprivation of Liberty Safeguards (DoLS). However, evidence was not always available to show that decisions for people who lacked capacity had been made in their best interests.

Staff informed us that appropriate checks had been carried out before they started work. These included Disclosure and Barring Service checks, previously known as Criminal Record Bureau (CRB) checks.

We looked at staffing levels at the home. The registered manager told us that she still needed to recruit two more nurses. Some staff and relatives informed us that more staff would be appreciated.

Staff were appropriately trained and told us they had completed training in safe working practices and were trained to meet the specific needs of people who lived there.

People were positive about the food at Willow Court. Relatives said that people's nutritional needs were met. We observed that people were offered regular drinks throughout the day.

Staff were knowledgeable about people's needs and we observed that care was provided with patience and kindness and people's privacy and dignity were respected.

A new activities coordinator had started work the week prior to our inspection. We considered however, that further improvements were needed in order to ensure that people's social needs were met.

We noted that new procedures which had been introduced should people fall, were not always followed. In addition, there was no proforma in place to guide staff about what actions they should take following a fall.

Staff, people and relatives were positive about the changes that the registered manager had made. One relative told us, "This is the best home around here. I've got a friend who lives in [name of another care home] and it's not a patch on this home." They expressed concern that the registered manager was leaving at the end of August 2014. There was no deputy manager in place and the regional manager was leaving a week after our inspection. We found that actions had not been taken to address some of the concerns that were identified in a recent medication audit. In addition, we found concerns with the cleanliness of the environment which had not been highlighted in the provider's checks.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These related to safeguarding people from abuse, cleanliness and infection control and medicines management.

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

Summary of findings

Following our inspection and prior to the publication of the report; we spoke with the regional manager. She informed us that a new manager had been appointed and had started work. She said, "[Name of manager] has made some really positive changes. Everything that was highlighted in the inspection has been addressed."

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Not all aspects of the service were safe. We found that one safeguarding incident had not been reported to the local authority safeguarding team and there had been a delay in taking appropriate action following a second incident.

We observed that not all areas of the home were clean. There was a smell of stale urine in the corridors and some of the bedrooms we checked.

We had concerns with certain aspects of medicines management such as the recording and storage of medication.

We found that the service was meeting the requirements outlined in the Deprivation of Liberty Safeguards (DoLS). However, we noted that evidence of best interests decisions were not always available to show that decisions for people who lacked capacity had been made in their best interests.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective. We saw that people and relatives were involved in people's care and were asked about their preferences and choices.

People received food and drink which met their nutritional needs. They received care from staff who were trained to meet their individual needs.

People could access appropriate health, social and medical support as soon as it was needed. We had concerns however, that the adaptation, design and decoration of the premises did not always meet the needs of people who lived there.

Is the service caring?

Good

The service was caring. During our inspection, we observed staff were kind and compassionate and treated people with dignity and respect.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views and wishes for people who are not able express their wishes.

Relatives told us that they were involved in people's care. Surveys were carried out and meetings were held for relatives and friends.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive. The home communicated with relevant health and social care professionals to make sure people received the right care to support any change in their needs.

Summary of findings

A new activities coordinator had started work the week prior to our inspection. We considered however, that further improvements were needed in order to ensure that people's social needs were met.

We found that new procedures which had been introduced if people had fallen were not always followed. In addition, there was no proforma in place to guide staff about what actions they should take following a fall.

A complaints process was in place. The actions taken in response to complaints were recorded.

Is the service well-led?

Not all aspects of the service were well led. Most staff said they felt well supported and were aware of their rights and their responsibility to share any concerns about the care provided at the service.

Although staff and relatives were pleased with the changes the registered manager had introduced, the service was about to go through another period of change. There had been three registered managers at Willow Court in the past four years. The present registered manager was due to leave at the end of August 2014. Staff told us that this had led to some uncertainty within the home. The regional manager informed us that a new manager had been appointed.

The provider carried out a number of checks on all aspects of the home. We found however, that these audits had not identified some of the concerns which we found during our inspection, such as the cleanliness of the environment and medicines shortfalls.

Requires Improvement

Willow Court Care Home

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors, an inspection manager and an expert by experience, who had experience of older people and care homes. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Most of the people who lived at the service were unable to communicate with us verbally because of the nature of their condition. We therefore 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.

We spoke with two regional managers, the registered manager, four nurses (one of whom was an agency nurse), nine care workers, an activities coordinator, the chef and a domestic assistant. We looked at seven people's care records and five staff files to check recruitment procedures and details of staff training.

We spoke with two people who were able to communicate with us and seven relatives to find out their views. In addition, we spoke with two local authority care managers and a community psychiatric nurse (CPN) who were vising the home on the days of our inspection. We contacted a GP and another CPN by phone following our visits. We also consulted with a local authority contracts and monitoring officer; two local authority safeguarding officers and the lead nurse from the local clinical commissioning group. We emailed the local Healthwatch organisation to obtain their views. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before our inspection, we reviewed all the information we held about the service. The provider sent us a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

Most relatives told us that they thought their family member felt safe. Comments included, "He feels safe – definitely", and, "I feel safe knowing he's there. He doesn't get distressed."

We spoke with staff who were knowledgeable about what actions they would take if abuse was suspected. They told us that they had not witnessed anything which concerned them. One member of staff told us, "We have nothing to hide. If I saw anything concerning, I would go straight to [name of registered manager]." Another said, "I would have no hesitation in raising any safeguarding issues to the manager or the nurse." We read the minutes of a recent staff meeting which was held on 23 July 2014. The registered manager had written, "We are the eyes and ears for our residents and we must maintain their well-being and safety at all times."

We were contacted by the local authority safeguarding team prior to our inspection. They informed us that there had been a delay in taking appropriate action following a recent allegation of abuse. We spoke with the registered manager on the first day of our inspection about this incident. She admitted that there had been a delay because she had been waiting for her line manager's approval for the proposed action that she was going to take. She explained that this had been a learning experience for her and the situation would not happen again.

Heads of department meetings known as "flash meetings" were carried out each day. The registered manager held these meetings with nursing staff, the cook, maintenance man and house keeper. We read that one person had been physically aggressive to another individual. The GP had been called to check that both individuals were alright. The registered manager had written, "Haven't put into safeguarding as an isolated incident. Staff/nurses to monitor and keep me informed." We were concerned that this incident had not been reported to the safeguarding team regardless of whether it had been an isolated incident or not. In addition, the Care Quality Commission had not been notified of the incident.

We were concerned that there had been a delay in taking appropriate action for one safeguarding incident and another had not been reported to the safeguarding team.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

We spoke with a local authority safeguarding officer following our inspection. She told us that the registered manager had organised further safeguarding training for all staff.

We did not plan to look at infection control procedures; however we had concerns with the cleanliness of the home.

All providers of health and social care have to comply with the Code of Practice for health and social care on the prevention and control of infections, and related guidance. We found that criterion two of this code, which requires the service to provide and maintain a clean and appropriate environment was not being fully met.

There was an odour of stale urine on the ground and first floor corridors and within some of the rooms we looked in. This was confirmed by two of the relatives with whom we spoke. One said, "The only thing I don't like is the odour of wee." Another relative said, "The smell is worse downstairs" and "Cleanliness isn't good." One relative said however, "[Name of registered manager] has worked wonders. You don't get the smells anymore." We found that many of the armchairs in the lounge on the ground floor gave off an offensive smell when we sat down on them. This was confirmed by one of the relatives with whom we spoke. She told us, "I don't like to sit in there [lounge], the chairs smell."

We checked people's bedrooms with their permission. We went into one bedroom on the first floor and found faeces on the floor. In another bedroom on the first floor there was faeces on the floor, the armchair and both on top and inside of a chest of drawers.

We looked in the sluice room which was used for the disposal of bodily waste. We observed that spare moving and handling slings were stored here. This was an infection control risk since bacteria could be transferred onto the fabric hoist slings. We saw that the floor was unclean and stained.

We saw that cleaning schedules were in place. However, these had not always been completed regularly. We noted that the cleaning schedule located in the sluice room,

indicated that this room had not been cleaned since April 2014. We spoke with the registered manager about our concerns. She informed us that there were normally no issues with infection control or the cleanliness of the premises. She said that she would address our concerns immediately.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

Following our inspection, the regional manager informed us that new flooring had been fitted in the ground floor corridors and new armchairs had been bought for the ground floor lounge which had helped reduce the malodour in the ground floor accommodation.

We looked at medicines management at the home. People and relatives did not raise any concerns about medication procedures. The CPN told us, "They have a good relationship with the GP's and medication changes are done quickly."

We observed a member of staff giving people their medicines. The nurse followed safe practices and treated people respectfully. People were given time and the appropriate support needed to take their medicines.

We looked at 17 medicine administration records (MARs). We saw that the majority of records contained a photograph of the person and any known allergies. We noted however, that some handwritten entries on MARs had not been signed by a second member of staff to confirm that they were accurate and complete.

We noticed that nine people did not have a care plan for 'as required' medicines. As required medicines are those given only when needed such as for pain relief. This meant that guidance to make sure that staff administered medicines in a safe, consistent and appropriate way was not always available, so people may not always receive their medicines when they needed them.

A daily check of medicines which had been administered was in place. However, this audit had not been completed for two days prior to our inspection. We checked 17 people's medicines and found that the amount of medicines for two people did not tally with the amount of medicines which should have been in stock. This meant that it was not possible to ascertain whether all medicines had been given to these two people as prescribed.

One person was prescribed a small dose of sedative medicine [quarter of a tablet]. We spoke with the nurse and asked how they administered such a small amount. The nurse told us that it was very difficult and that tablets or part tablets were often lost. We could not see any evidence that a discussion had taken place with the GP about changing the medicine to liquid form or an alternative medicine.

We checked the storage of medicines. We saw that fridge and room temperatures were monitored to ensure that the temperature remained suitable for the storage of medicines.

We noted however, that the temperature in the first floor medicines room had been consistently high for a number of months. Storing medicines at the correct temperature is important to ensure that medicines are kept, safe, stable and effective. We spoke with the manager about this issue. She told us she had raised this with the provider's maintenance team, but had not heard back about what action was going to be taken.

We looked in the medicines fridge on the first floor and noticed a medicine pot with liquid medicine was stored there. There was no indication what the medicine was, who it was for, or how long it had been there. We noted that eye drops were stored together in a dish. We saw that the dish was sticky with what appeared to be leaked eye drops. The printed instructions on the labels of several eye drop bottles had run and were not clear.

We noticed that topical creams and ointments were stored in people's rooms and that in some; there were stock piles of certain creams and ointments. We counted eight tubs of a particular cream in one bedroom. This showed that not all medicines were ordered appropriately according to need.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the action we have asked the provider to take can be found at the back of this report.

We spoke with staff about staffing levels at the home. Some told us that more staff would be appreciated. However, a

Inadequate

Is the service safe?

new member of staff said, "I feel there is enough staff, they are so helpful with me being new and they have a good rapport with each other." A relative with whom we spoke said, "From what I have seen yes there are enough staff." However, another stated, "I don't think there's enough staff. They keep saying I'll be there in five minutes."

On the days of our inspection, there were two nurses on duty. The manager explained that staffing levels had been increased during the day from six to seven care workers which included a senior care worker. She told us that she was in the process of recruiting a further two nurses to work at the home. We spoke with a senior care worker who told us, "Staffing levels have been upped to seven. We oversee both floors and see what's going on…We allocate some of the jobs." Some staff told us that eight care workers would be appreciated; four on each floor.

We noticed that most people sat in the ground and first floor lounges. Staff were allocated to sit in the lounges to monitor people and check people were safe. We saw that other areas of the home were not utilised so frequently, such as the garden areas and other communal rooms. One relative told us that this was because they did not have enough staff to support people to access these areas. She told us, "This room [another lounge area] never gets used. They like them all in the other lounge so they can have one member of staff watching them all." We spoke with the registered manager about this comment. She informed us that people were free to go wherever they chose. We did not see many interactions between staff and people who stayed in their bedrooms. One staff member said, "Having four staff [and one nurse] on each floor would give us more time so we could spend more time talking with them [people] like [name of person]. We just don't have the time."

There was one nurse and four care workers to look after people at night. Staff on night duty with whom we spoke, informed us that there were enough staff on duty to meet people's needs, although more staff would be appreciated.

Staff told us and records confirmed that recruitment checks were carried out before staff started work to ensure that they were suitable to work with vulnerable people. Disclosure and Barring Service checks, previously known as Criminal Record Bureau (CRB) checks and written references were obtained. One member of staff said, "I have had all the necessary checks carried out, DBS, reference from previous employer and a personal reference."

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. The registered manager was aware of the Supreme Court judgement regarding what constituted a deprivation of liberty. She told us that she was liaising with the local authority regarding what impact the ruling had on the people who lived at Willow Court. She explained that two applications to deprive individuals of their liberty had been approved by the local authority. We spoke with a local authority care manager for one of these people. She told us, "They've done wonders with him [person]. There's a DoLS in place." She told us the correct procedure had been followed.

We noted that some people required their medication to be administered covertly. Covert medication refers to medication which is hidden in food or drink. The Nursing and Midwifery Council state, "The covert administration of medicines is only likely to be necessary or appropriate in the case of patients or clients who actively refuse medication but who are judged not to have the capacity to understand the consequences of their refusal." There was no evidence that best interest meetings had taken place for each person who had their medicines administered this way to ensure that it was in their best interests. We considered that it was not always clear that staff acted within the principles of the Mental Capacity Act 2005.

Requires Improvement

Is the service effective?

Our findings

People and relatives with whom we spoke did not raise any concerns about food at the home. One person said, "Yes I like the cooked food." Another stated, "They bring me cups of tea or food." A relative said, "She has a soft diet and has substitutes like milkshakes. She is constantly monitored for her weight." Other comments included, "The care is excellent. I go in most days. He has a thickened drink which they prepare and help him with," "He certainly eats well. He has a pureed diet; he's always supervised at meal times. I sometimes go in and the food looks excellent", and, "I think the food is good."

We spent time with people at lunch time on both days we visited. Staff supported people to go to the dining rooms for meals. We noticed that there was a delay in serving lunch on both days of between 30 and 40 minutes. Some people became restless and walked away from the table. They required persuasion to return when the meal was eventually served.

We observed that assistance and support was offered discreetly on a one to one basis. Some people required their food to be pureed or a soft consistency. We saw that pureed meat and vegetables were served in distinct portions on the plate, rather than being pureed together. The cook explained that this was to make the meal more appealing. Portions varied according to people's needs. Some portions were larger; others were given a smaller amount and offered second helpings if required.

Staff communicated with people throughout their meal and observed people to make sure they were managing their meal. Some required full support to eat and drink, others needed assistance to cut up their food; others required prompting only. We heard one staff member say, "Just a little more – a couple more mouthfuls and then we'll see what's for pudding."

People were offered regular drinks during lunch and also throughout the day. Each lounge area had a 'drinks station' with juice in a jug and glasses. We noticed that each person was given a glass of juice. Because there were no tables in the lounge areas, very often the glass of juice was out of sight on the floor. We observed staff encouraging people to drink and the jugs were refilled at regular periods throughout the day. Staff told us and our own observations confirmed that people's diet and fluids were monitored. One night staff member told us, "If anyone has had a poor dietary intake or poor fluids that day; we will check and encourage them to have more overnight."

We looked around the kitchen and saw it was well stocked with a range of fresh, dried and refrigerated/frozen goods such as vegetables, fruit and salad ingredients, meat, eggs, cheese, milk and cream. A four week menu planner was in place. This was amended and adapted to reflect people's choices or requests.

Kitchen staff had written information about individual requirements and any likes and dislikes. They had a good understanding of people's needs and they served the meals. The cook stated that this enabled him to monitor how well people were eating and observe directly if people were struggling with their food or if their needs had changed.

We checked people's care records and noted that nutrition care plans were in place. These identified requirements such as the need for a diabetic or modified textured diet. Risk assessments were in place to identify if the individual was at risk of choking or malnutrition. We noted that the appropriate action was taken if any concerns were highlighted. We saw that people had been referred to the dietitian and speech and language therapist.

Two people required feeding via a Percutaneous Endoscopic Gastrostomy (PEG) tube. This is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medication. One of these individuals was able to eat pureed food in addition to being fed via his PEG. We spoke with this person's relative who told us, ""[Name of person] has to be PEG fed. They've also got him on 'whooshy' [pureed] food. The speech and language therapist came in and he's now having yoghurt. He's had no weight loss."

People and relatives with whom we spoke did not raise any concerns about the skills and experience of staff. One relative said, "They do very well with the new system of training schemes. I used to be in training of apprentices. I talk to the staff quite frequently. They all have NVQ's. Yes they definitely have the skills that they need." Other comments included, "Staff are well trained and know the

Is the service effective?

rules. They have been here a long time. The nurses sometimes change" and "From what I see I think the staff have the skills. The local authority care manager said, "I have no concerns about the competency of staff."

Staff told us that they had access to training in safe working practices and to meet the specific needs of people who lived at the service. One member of staff said, "We have e learning and for the seniors we have wound care training. I've done first aid training and I've just done dementia care." Another member of staff explained that other health and social care professionals were involved in delivering training. She told us, "The behavioural team came in to talk to us about one resident. They told us how his past can give us clues to some of his behaviour now and how we can deal with this…It's given me much more of an insight into him and his care."

Staff explained that the majority of training was e-learning rather than face to face training. One member of staff explained that she had difficulty with this type of training since she had dyslexia. The registered manager explained that face to face training was available and some staff had completed bowel management training.

Staff gave us examples of how training had changed their practice. One care worker explained that following training on fluid levels, she was now more aware of the importance of giving people regular drinks to ensure that they did not become dehydrated. Two staff talked about the "resident experience" training they had recently undertaken. One care worker told us, "It's where we are fed and led along the corridors. We have staff feed us and we see what it's like when staff don't talk to us." They told us that this training had made them much more aware of their actions and the importance of interacting with people.

We spoke with staff who had recently started working at the home. This included a care worker and activities coordinator. They said that they had been given a two day induction and had to complete a number of required training courses such as moving and handling. They said that they had also spent time shadowing experienced staff and getting to know people individually. The activities coordinator said, "There is another activity worker at Willow Lodge [another home owned by the provider on the same site as Willow Court] so I want to meet with them and talk to them to get a feel of what they do and what is happening with regards to activities. I am learning through listening to and talking with the residents…Yes – I feel supported."

We read people's care records and noted that people had access to a range of health and social care professionals including GP's, dietitians, CPN's, speech and language therapists, social workers, opticians and podiatrists. This was confirmed by those health and social care professionals with whom we spoke, including a GP, social worker and CPNs. They told us that staff contacted them in a timely manner if there were any concerns.

We did not plan to look at the adaptation, design and decoration of the premises. However, we identified some concerns with this area during our inspection.

The National Institute for Health and Care Excellence (NICE) states, "Health and social care managers should ensure that built environments are enabling and aid orientation."[NICE, Dementia - Supporting people with dementia and their carers in health and social care, November 2006:18]. We found however, that not all of the premises were "enabling" and aided orientation.

The registered manager told us and our own observations confirmed that staff had started to decorate certain areas within the home, including the corridors. However, we saw that not all areas had been decorated to support those who were living with dementia. Many of the walls were painted in the same colour with few discernible features. We ourselves got lost accessing various places within the home.

We observed that most people sat in the main lounge on the ground and first floor. These two lounges were relatively small. We saw that each available seat was taken and the seating was arranged in a circle around the room on the first day of our inspection. We considered that this seating plan did not promote communication or socialisation. The registered manager explained that the chairs were not usually set out in this way. She explained that they were normally arranged in a way that promoted conversation and was less institutionalised. One relative told us, "They're always sitting round in a circle and it's quite intimidating." She explained that she liked to use one

Requires Improvement

Is the service effective?

of the quiet rooms which were available, but not often used. She said however, that more could be done to make the "quiet rooms" more homely. She told us, "More books and things for them to look at and feel would be good."

The CPN told us, "They don't make full use of all the space or recognise that people can go outside." We checked outside and saw that the garden area at the rear was not well maintained. The grass was long and the borders and hedgerows were overgrown. There were three large raised garden beds which were all empty. Although the weather was sunny on both days of our inspection, we did not see people access the garden areas on either day. We considered that not all garden areas were pleasant or stimulating places for people in which to sit.

The registered manager had identified the need to improve the environment to ensure that it met the needs of people who lived there. We read the PIR which stated, "Applied for extra funding to FSHC [Four Seasons Health Care] to improve surroundings and improve the holistic needs of the residents. To source money then spend it appropriately within the home and garden." During the inspection, the registered manager informed us that she had acquired the extra funding from the provider and this would be used to improve the environment.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring. One relative said, “They treat [name of person] like their own grandpa”, and, “He smiles at them so I know that they care for him.” Other comments included, “It’s one of the best homes in the area for care, it’s very caring,”, “The staff are very caring,” “His care has been excellent. I could not fault the care,” “He does get excellent care,” “The care is pretty good. Yes I think they encourage him to use his skills, if he needs shaving etcetera. My son will come and help him shave; he has got to keep independent,” “I am happy yes and they are kind,” “They seem to be caring”, and, “This isn’t a job for staff, they do it because they care.”

We spoke with a GP who told us, “The care seems to be appropriate”, and, “I’ve got no concerns.”

We saw positive interactions between people and staff. One person said to a care worker, “I love you, you know.” The care worker replied, “I know and gave her a hug.” All interactions we saw between people and staff were positive. Another care worker said, “Would you like some chocolate? Yes? I know you love your chocolate.” The care worker gave the person one of her chocolates which she enjoyed eating.

We noticed positive interactions, not only between care workers and people, but also other members of the staff team. Both the cook and domestic staff made time to speak with people. We saw that these interactions were appreciated.

Relatives told us that staff promoted people’s privacy and dignity. One relative said, “They always preserve his dignity. If he spills anything on his top, they help him change it.” Other comments included, “Yes they show respect and dignity, they don’t have choice with me being here every day”, “They do show respect and dignity.” Most of the people we saw were well presented. One person had pulled her skirt up above her knees. A care worker saw this and quietly went over and helped the person rearrange her skirt. Another care worker came to the aid of someone who was restless and on the move. She supported the person to walk to her room where she used the toilet. The care worker then assisted her onto her bed where she had a sleep before lunch.

Staff provided us with examples of how they maintained privacy and dignity. One staff member said, “If a resident needed their top changing after lunch, I would always take them to their room to help them get changed.” We saw that staff knocked on people’s doors before they entered their rooms. One person needed to have her blood taken. The nurse took her to her bedroom so that he could do this task in private.

We read the minutes from a recent unannounced visit at night which was carried out on18 July 2014 by a regional manager. She had written that staff should consider placing blankets over people’s knees when they were sitting in their night wear to promote their comfort and dignity. We spoke with members of staff from night shift who said that this was being carried out.

Relatives told us that they were involved in people’s care. They also told us that meetings were held for people who lived there and their relatives. The local authority care manager told us, “The home is good at listening to residents.”

Requires Improvement

Is the service responsive?

Our findings

We spoke with relatives about whether staff responded to people's needs. Comments included, "If [name of person] has an accident, if his pad is wet, they are there within seconds to help him to change." Other comments included, "The medical care is fine. About three weeks ago he had a shaking do when I was there. Two nurses came and the doctor was called and they took his temperature and blood pressure and he seemed to be okay, it passed," "He had a fall out of bed. Now they've put bedsides up and he's had no further falls out of bed," "They've done their best and got him a high low bed because he's had falls in the past" and "[Name of person] had a temperature and staff monitored him and kept me informed."

The local authority care manager told us, "They contact me if there are any problems. When she [person] was physically unwell they contacted me. They reacted quickly to her infection." The community psychiatric nurse told us, "I've got two residents in here. They've implemented the plan of care for both residents well" and "They do use and seek our advice and on the whole follow our advice."

We spoke with day and night staff about how they were responsive to people's needs. One new member of day staff said, "The home is good at being there for the residents and their needs and recognising this, for example with toileting and personal care and assistance with their diet. There is nothing that I would improve so far." "We have a lady who has type one diabetes. We monitor her blood sugars which are low sometimes so she has to have milk and sugar. You always have to be aware."

The registered manager told us and records confirmed that preadmission assessments were carried out before people moved into the home. She explained that these were carried out to ensure that staff could meet people's needs and that the home had the necessary equipment to ensure their safety and comfort. The local authority care manager said, "I was happy with the admission process. I feel they work with you."

We spoke with people, relatives and staff about activities provision at the home. The CPN stated, "My concern is that there is a lack of general activity in the home." A new activities coordinator had started work only the week before our inspection. One member of staff told us, "Activities haven't really been happening." Staff informed us that they hoped that activities both within and outside the home would improve with the employment of the new coordinator.

Although we observed positive interactions between people and staff in the lounges and dining rooms, we did not see many interactions between people who remained in their rooms and staff. We saw one person, sitting in her nightdress in her bedroom all day. Staff explained that she preferred to wear her night dress. She sat in her bedroom with no television or radio on. A care worker introduced us to this individual and she enjoyed talking to the staff member about winning the lottery. We passed her bedroom throughout the day and noticed that she continued to sit in her armchair with her nightdress on with nothing to occupy her attention. We spoke with the registered manager about this person. She told us that she would look into obtaining a television for her. A relative whose family member also stayed in their room for most of the day commented, "They do well – they are good; the door is never closed as I ask for it to be open and it always has been like this. They can see and they pop in."

Although a new activities coordinator had been employed, we felt, that further improvements were needed in this area to ensure that people's social needs were met.

We read the minutes of a staff meeting which had been carried out on 23 July 2014. The registered manager had written, "There has been an influx of falls on nights and I am unsure why. Staff are to sit in hallways, not in lounges…More responsive action can be achieved when the staff are placed in the hallways as this enables them to hear residents more clearly and observe if anyone is wandering."

We spoke with staff on night shift. They confirmed that they now sat in the corridors so that they could respond more quickly if there were any concerns. One member of staff told us, "We try and minimise falls. One resident has a sensor pad upstairs and there is one lady waiting for a sensor pad."

The registered manager told us that a new procedure had been put in place regarding falls. This procedure had been implemented to ensure that appropriate action was taken and medical attention sought if an injury that required medical attention was suspected. The registered manager had submitted two notifications to inform us that two

Requires Improvement

Is the service responsive?

people had sustained fractured hips. We read that both people's injuries were not identified immediately. A week after our visits, we received a further notification that a third person had fallen. We read that there had been a delay in identifying that the person had fractured their hip. All three people had been moved by staff who had used a moving and handling belt to stand the person up and assist them to their chair. First Aid guidance states that if a fracture is suspected, the individual should not be moved since walking or even standing can cause the fracture to spread, which may worsen the pain.

We checked the records of two people who had fallen. We noticed that observations of their physical health were documented, including their blood pressure and pulse. The length of time that each person was monitored was dependent upon individual nurses. There was no specific monitoring proforma in place to guide staff into the actions they should take following a fall.

We considered that further improvements in this area were required to ensure that appropriate action was taken and consistent monitoring carried out to make sure that any concerns were identified in a timely manner.

There was a complaints procedure in place. We noted that the actions taken to address complaints were recorded. Several relatives had not been happy with the action taken in response to their complaint. The regional manager informed us that if relatives were unhappy with the manager's response, the complaint would be passed to them to investigate. The regional manager informed us that often a face to face meeting was arranged so their concerns could be discussed further.

Relatives with whom we spoke on the days of our inspection said, "I've never had to complain. Once I had to say that his shaving wasn't being done very well and they took it very seriously and things improved." Another said, "Complaints – no not really because I talk to the staff a lot. Paula has been very good."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post. She had registered with the Care Quality Commission in December 2013. Most staff spoke positively about the manager and working at the home. Comments included, "Since the change of management in the last year there has been a marked improvement;" "Paula has done really well. I do feel supported" and "Morale has improved a lot."

Comments from relatives included, "The atmosphere is good - it's nice. The service seems to be managed well. I would suggest that there could be a bit of redecoration. His bedroom is lovely, but there should be proper industrial flooring, it needs a bit of a revamp, the passages etcetera," "The firm have certainly improved and it was mine and my son's first choice four years ago," "Paula is a good manager" and "Overall it's well run. Paula will listen to concerns."

Health and social care professionals also spoke positively about the registered manager. The local authority care manager stated, "[Name of registered manager] has turned it around. There's certainly been improvements" and "They've been great. [Name of registered manager] has done really well." The CPN stated, "The manager is good at what she does."

Although staff and relatives were pleased with the changes the registered manager had introduced, the service was about to go through another period of change. There had been three registered managers at Willow Court in the past four years. The present registered manager was due to leave at the end of August 2014. One relative said, "We have a good manager, but she's leaving soon. We've had three managers since [name of person] has been here." The regional manager was also due to leave the week after our inspection. The regional manager told us that a new manager had been appointed.

The registered manager was not a registered nurse and there was no clinical lead [deputy manager] in place. She explained that clinical leadership was provided by the nurses on duty. This meant there was no designated lead in place to oversee the clinical aspects of care which staff provided. The registered manager told us that she needed to recruit a nurse and a clinical lead [deputy manager] who also needed to be a nurse. One member of nursing staff informed us that increased clinical supervision was needed.

The provider carried out a number of checks on different aspects of the home. These included health and safety; infection control; medication and care plans. We found however, that these audits had not identified some of the concerns which we discovered during our inspection, such as the cleanliness of the environment. We noticed also that no action had been taken to address the issues raised in a medicines audit, carried out by an external pharmacist on 25 June 2014. A number of areas for improvement had been highlighted such as ensuring that staff double signed all handwritten entries. The registered manager explained that nursing staff should have taken action to address the issues outlined in the medication audit because of their knowledge of medication.

During our inspection, we found that we had not been notified of a safeguarding incident. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns. The registered manager explained that the failure to notify the Care Quality Commission on this occasion had been an oversight on her behalf. The registered manager had informed us of other notifiable events such as serious injuries and deaths.

Relatives told us and records confirmed that meetings were held for people and relatives. One relative said, "They have relatives meetings once a month. If you have any complaints you go and talk about things. They'll do their best to address things." The local authority care manager stated, "Paula works very hard with relatives. She gives them time." We read the minutes from the most recent meeting which was carried out 19 June 2014. The redecoration of bedrooms was discussed. We read that relatives had requested minutes of meetings to be sent via email. The registered manager told us that this would be organised.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **People who used the service were not always protected from the risk of abuse because the registered manager had not always responded appropriately to any allegation of abuse. Regulation 11 (1)(b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were not always cared for in a clean environment. Effective systems were not fully in place to reduce the risk and spread of infection. Regulation 12 (1)(a)(b)(c) and (2)(a)(c)(ii).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately. Regulation 13.**