ADL Plc

The Willows

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Willows is a residential care home that provides accommodation and personal care to people aged 65 and over, some of whom maybe living with dementia. At the time of this inspection 14, people were living at the service.

People's experience of using this service and what we found
There continued to be a lack of oversight and systems in place to drive forward improvements since the last inspection. Similar concerns were still identified in relation to medicines administration, risk management and good governance systems.

Infection control practices were not robust and placed people and staff at risk of spread of infection. Medicines continued not to be managed safely. Despite numerous assurances received from the provider about medicines management, errors were still identified which place people at risk of harm.

Staff continued to not receive adequate induction, training or supervision to ensure they had the appropriate skills and knowledge to support people. People continued to not always be safeguarded from the risk of abuse as oversight of these systems were not effective and the provider failed to take action when required.

Some people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the policies and systems in the service did not always support this practice. The recommendation we made at the last inspection about this had not been fully met or embedded in practice.

Recruitment checks were in place, but we identified some gaps. We made a recommendation about this. The number of staff required was determined by a tool used by the provider. The tool had not been completed properly and the provider could not be assured they had a sufficient amount of staff in place. We made a recommendation about this. There continued to not be a registered manager in post. The previous manager left before the inspection.

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

Rating at last inspection
The last rating for this service was Inadequate (published 20 December 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations and continues to be rated inadequate. This is the sixth consecutive inspection that the service has been rated below good.

Why we inspected
We received concerns in relation to the administration of medicines. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

The overall rating for the service remains inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to medicines, assessing risk, infection control, health and safety staff training and support, safeguarding and governance.

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

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

inadequate for any of the five key questions, it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Willows

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors attended the inspection on both days.

Service and service type
The Willows is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. Having a registered manager means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

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

make.

During the inspection
We spoke with a director, an operations manager and a senior care worker.

We reviewed a range of records. This included six people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We asked for assurances regarding urgent risks we identified on the first day of the inspection. We returned on the second day of inspection to check if these urgent risks had been met. We continued to seek further information from the provider to support the inspection. Not all information we requested was provided, including contact details for staff. We spoke with three relatives of people using the service.

Inadequate

Is the service safe?

Our findings

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

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

Using medicines safely

- People's medicines continued to not be managed safely. Despite assurances given by the provider to CQC and the local authority since the last inspection, the competency of staff administering medicines had not improved and medication errors had been made.
- People continued to not receive their medicines as prescribed. Staff lacked knowledge about 'as and when required' medication which led to a number of people not receiving their medicines when they should have. This included prescribed medicines to be taken at regular times. Where protocols were in place to help guide staff when to administer 'as and when required' medicines, they were of poor quality.
- We continued to find concerns regarding the use of covert medicines. The necessary documentation to support staff when and how to administer this was not in place. This led to the medicine being inappropriately administered. Following feedback given after the first day of inspection and the Commission imposing conditions on the providers registration regarding safe medicines practices, the provider updated their records for covert medicines.
- People continued to not have access to their medicines every night-time as not all night staff were trained to administer them. A protocol was in place for staff to ring senior management if someone wanted any medicine during the night. Following the first day of inspection the provider took action to ensure staff were available during the night to administer medicines.
- People who were unable to communicate if they were in pain were not having their pain assessed. Appropriate methods to assess people's pain levels were not in place and there was no evidence of this being considered.

Failure to have systems in place for the safe administration of medicines was a continued breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Care plans and risk assessments continued to be out of date and did not guide staff how to deliver safe care and reduce risks. This included when people had health conditions or significant changes in their care needs. Following feedback after the first day of inspection, the provider updated some care plans and risk assessments.
- Accident and incidents were recorded however there was limited evidence of this being analysed or any lessons learnt.
- There continued to be some health and safety checks which had not been carried out even though this was identified at the last inspection. This included fire extinguisher checks and wheelchair checks.

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

Preventing and controlling infection

● We continued to not be assured that the provider was meeting shielding and social distancing rules. There were no risk assessments in place for the use of communal spaces or individual assessments for those who were clinically vulnerable.

● We were not assured the provider was using PPE effectively and safely. Staff were observed to not be wearing or change the appropriate PPE when supporting people who were COVID-19 positive.

● We were not assured that the provider was accessing testing for people using the service and staff. There was no clear system in place for checking staff were testing in line with guidance. No one had oversight of this.

● We were somewhat assured that the provider was admitting people safely to the service. Some processes were not in place to support safe admissions.

● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Not all visiting healthcare professionals were asked for proof of vaccination on entering.

● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. There were some gaps in cleaning records and some equipment required cleaning/replacing.

● We were somewhat assured that the provider's Infection Prevention and Control (IPC) policy was up to date. Policies had been reviewed. However, people who lacked capacity to consent to regular testing did not have a best interest decision in place.

● We were somewhat assured the provider was facilitating visits for people living in the home in accordance with the current guidance. People's relatives told us they made visits to the service although some said they had not been allowed to meet in their relative's room.

● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Processes were in place to manage this however, these were not always followed, for example, the use of PPE.

The provider had failed to ensure effective IPC measures were in place. This is a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People were still not protected from the risk of abuse. Medication errors continued to place people at risk. The provider failed to investigate all safeguarding concerns within a timely manner.

● The services safeguarding log continued to not reflect all safeguarding matters. This meant there was not clear oversight of safeguarding concerns.

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

Staffing and recruitment

● The provider could not be assured there was enough staff to meet people's needs. The tool the provider used to assess the staffing levels was still not completed accurately. People who required 1-1 care or regular checks had not been considered on this tool.

● Recruitment checks were in place. We identified one person who did not have an up to date DBS in place. The provider told us an application was in progress.

We recommend the provider seek advice and guidance from a reputable source, about safe recruitment process and how to assess and monitor staffing levels.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience
- Staff continued to not be adequately supported in their roles. Staff continued to not receive regular supervision. There were no records of inductions for new staff.
- The quality of competency assessments was poor and continued concerns about staff's competency to carry out their roles were identified.
- The providers training matrix continued to demonstrate that staff training was out of date or had not been completed. Staff were still not trained in areas to meet people's needs such as dementia and catheter care.

The failure to ensure staff received sufficient support, supervision and training is a continued breach of Regulation 18, (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- There was a lack of clear oversight of DoLS applications were made to authorise restrictions on people's liberty.
- Some decisions around COVID-19 and regular testing had not been recorded in line with MCA principles.

Assessing people's needs and choices, delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
- Information gathered through assessments carried out prior to people being admitted to the service was

not used to create a plan for person centred care.
● Improvements had been made in some people's bedrooms. Conditions had generally improved, and some people's space was personalised.

Supporting people to eat and drink enough to maintain a balanced diet: Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Mealtime choice had been improved. An external company was now providing meals which enabled people to have more choice around what they ate.
● Some monitoring charts were in place to monitor people's food and fluid intake. However, some people who required their fluid to monitored due to health conditions did not have this in place.
● Records showed the home was working with health professionals when required.

Inadequate

Is the service well-led?

Our findings

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

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

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

- The provider had failed to ensure the service made the necessary improvements following the last inspection and having been placed in special measures. The service has a long history of failing to provide a good standard of care.
- There continued to be a lack of oversight of the service. The manager had left prior to the inspection and the provider had not been monitoring their progress whilst in post. Sufficient progress had not been made to improve the service.
- Audits in place were of poor quality. They had continued to fail to identify and act on the areas of concern we identified at the last inspection. The audits completed by the previous manager had not been closely monitored by the provider.
- There continued to be a failure to manage risks posed to the health, welfare and safety of people. This included safe administration of medicines, IPC and risk management. There was no oversight of the application of the MCA and recording of decisions made.
- The quality of accurate and contemporaneous records remained poor. People's care records contained limited information to be assured care was being delivered to meet their needs.
- The provider had failed to take necessary action to ensure people were receiving safe care in line with regulations and did not fulfil assurances given to CQC and the local authority.
- The provider failed to have systems in place to engage with and support the inspection process. Information was requested on multiple occasions before being provided. Some information was not provided at all, including contact details for staff.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- People did not receive person centred care in a positive and open environment. Care plans were not up to date, and staff were not trained to meet their needs. The provider was struggling to provide care which met people's basic needs.

● The service continued to not promote a culture of working with agencies and external partners to meet people's needs.
● Relatives we spoke with were not aware of management changes within the service. The provider had not made relatives aware of the outcome of the last inspection and that the service was in special measures.
● The provider demonstrated a understanding of the duty of candour.