Willowbeech Ltd

Willowbeech Limited - 33 Ophir Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 10 and 11 April 2017.

Willowbeech Limited – 33 Ophir Road is a care home for adults with a learning disability, including autism. It is registered for up to five people, although in practice only up to four are accommodated. Nursing care is not provided. Three people were living there when we inspected. Accommodation is provided in individual bedrooms with ensuite shower and toilet facilities. These are arranged in two flats, each with their own lounge and dining kitchen, one on the ground floor and the other on the first and second floors. The first and second floors are accessed via stairs. There is a parking area to the front of the house and a lawned garden to the rear.

The service is required to have a registered manager as a condition of its registration. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The previous manager had left at the end of 2016 and had applied to cancel their registration. The service was being managed by an acting manager, and a replacement manager had been recruited and was due to start in post in June 2017.

There were some shortfalls and areas for improvement.

There were enough staff to provide the support people needed. However, recruitment procedures were not robust in that full information was not available for all staff about past conduct in health and social care employment. You can see what action we told the provider to take at the back of the full version of the report.

Most accidents and incidents were identified, reported and investigated by staff. However, the system in place to monitor accidents and incidents at the provider's level was not robust. Whilst the provider reviewed a monthly report of accidents and incidents to identify any trends or patterns, some incidents involving the use of restraint had not been included in this as they should have been. This meant the provider could not be sure that appropriate action had been taken and plans put in place to protect people in future. You can see what action we told the provider to take at the back of the full version of the report.

The provider did not have effective systems in place to monitor and improve the quality of care and support that people received. Quality audits were not fully accurate and therefore did not identify actions staff could take to improve the experiences of people living at the home. They had not identified some of the issues we found during the inspection. Where audits had recognised shortfalls and staff had requested action, this had not always happened. You can see what action we told the provider to take at the back of the full version of the report.

CQC had not been notified, as it should have been, about some significant events affecting people's health and welfare. You can see what action we told the provider to take at the back of the full version of the report.

Internal health and safety audits had not identified hazards we found in relation to the premises. The acting manager addressed these when we drew them to their attention to make sure the environment was safe for people.

The arrangements for obtaining consent were not robust. The service did not routinely ask whether people had a representative with lasting power of attorney or powers delegated by Court of Protection to make decisions on person's behalf. The acting manager had not been given additional training about the Mental Capacity Act 2005 to enable them to take the necessary action.

Complaints were recorded but the acting manager was unable to access details of investigations and outcomes for complaints that preceded their appointment. We have made a recommendation regarding the handling, recording of and learning from complaints.

Other findings were positive.

People had the individualised care and support they needed, from caring and respectful staff who understood them well. People were relaxed and comfortable in the presence of staff.

Care plans were clear, thorough, up to date and centred on the person. People's individual risks were assessed and addressed through care plans.

People were encouraged to get involved in activities in the community and also to be involved in daily living tasks at home and in the community.

People were supported to visit and stay in contact with their families, and could receive visits at any time that suited them.

People were supported to manage their health, including consulting with health care professionals where needed. Care plans included Health Action Plans, which set out in a straightforward way their health needs and how these were to be addressed.

People were supported to have healthy diets with as much variety as they would accept, whilst respecting their food preferences. They were encouraged to get involved in food shopping and preparation.

Medicines were stored securely and managed safely.

Staff had the training they needed to give them the skills and knowledge to be able to support people. Staff told us they felt well supported by the acting manager, whom they said they could approach for advice or guidance at any time. Where there were gaps in training and supervision the acting manager had a plan in place to rectify these.

According to the provider's policy, staff should have had regular supervision meetings, at least every six to eight weeks. The acting manager acknowledged this had fallen behind, although their supervision plan showed that most staff had had a supervision meeting since the beginning of February 2017.

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

The service was not safe in all respects.

The system of recruitment checks was not robust, as references were not all available from candidates' most recent employers in health and social care.

Whilst staff reported accidents and incidents and these were investigated, the system for monitoring accidents and incidents at the provider's level did not ensure trends or patterns were identified to reduce the risk of a reoccurrence.

People were protected from abuse. Risks were assessed to minimise the risk of harm and were managed in the least restrictive way possible.

Is the service effective?

Good

The service was effective.

Staff involved people as far as possible in day to day decisions about their care. However, there was a risk that some people's rights would not be protected or decisions made in their best interests, as consent had been sought from family members who did not have a legal power to give this.

Staff felt well supported by the acting manager and had access to the training they needed.

People had diets rich in foods they liked and which met their dietary needs.

People had the support they needed to manage their health.

Is the service caring?

Good

The service was caring.

People received care and support from staff who understood them and treated them with dignity and respect.

Staff communicated effectively with people and actively involved them in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People and their families were actively involved in planning and reviewing their care and support.

People received the consistent, individualised care and support they needed. They were actively encouraged to get involved in activities at home and in the community.

Is the service well-led?

Requires Improvement

The service was not well led.

Quality assurance systems were not effective. Audits were not always accurate, and where shortfalls were identified these were not always acted upon. They had not identified the shortfalls we found.

Some significant events that should have been notified to CQC had not been.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received.

Willowbeech Limited - 33 Ophir Road

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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced comprehensive inspection took place on 10 and 11 April 2017. It was undertaken by two adult social care inspectors.

Prior to the inspection we reviewed the information we held about the service, including notifications about significant events, and feedback from health and social care professionals and the local authority contract monitoring team. We also obtained feedback from a further professional following the inspection.

On this occasion we did not ask the provider to complete 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.

During the inspection we met everyone who lived at the service, but they were not able to talk to us in detail about their experience of the service, or did not wish to do so. We also spoke with the acting manager and four other staff. We made general observations around the home and of staff supporting people, although we did not observe personal care.

We looked at four staff recruitment files, one person's care records in detail and elements of the other two people's care records, medicines records and other records relating to the management of the service, such as audits, complaints and staff training information.

Following our visits to the service we spoke with one person's relative.

Requires Improvement

Is the service safe?

Our findings

People were not able to tell us about whether they felt safe at the service. However, they all looked comfortable with the staff who supported them, and those who were able actively sought staff out to speak with. A relative who had regular contact with the service said they felt their family member was safe there.

The system of recruitment checks, to ensure staff were of good character and suitable for their role, were not robust. Two of the four staff recruitment files we checked contained all of the required information, including application forms, records of interview, appropriate references and criminal records checks with the Disclosure and Barring Service. The remaining two files did not contain evidence that the provider had assured themselves of the staff members' satisfactory conduct in previous health or social care employment. These staff had most recently been employed by agencies, from which there were no references on file. We drew this to the attention of the acting manager at the inspection. One had no references at all nor evidence of their photographic identity on file. Following the inspection, the provider advised us the agencies had not been willing to provide references, despite every effort on their part to obtain these. They had therefore asked the staff to provide alternative references. However, one of the files we reviewed did not contain any references and another had only one reference.

The failure to have information available in relation to some staff was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. The acting manager felt there were enough staff with the right skills to support people. They told us one waking and one sleep in member of staff supported people at night time. During the day there were three to four staff on duty, dependent on what activities people wanted to do. Our observations showed there were sufficient numbers of staff on duty to meet people's assessed needs, including supporting them with what they wanted to do.

Most accidents and incidents were identified, reported and investigated by staff. Records reflected a thoughtful approach to what had happened, what may have triggered the incident and how it was managed. Some people's freedom of movement sometimes needed to be restricted to varying degrees to protect them from harm. This was part of their plan of care and had been agreed by their circle of support as being in their best interests. Staff understood the importance of ensuring that where restraint was used, this was the least restrictive possible and for the shortest possible time. When restraint was used during the inspection staff constantly reviewed whether this was necessary. They also recorded within people's care records the use of restraint and attempts to remove it.

However, the system in place to monitor accidents and incidents at the provider's level was not robust, and did not ensure trends or patterns were identified to reduce the risk of a reoccurrence. The provider reviewed a monthly report of accidents and incidents, including where restraint was used. This was shared with the service, the provider's positive behaviour management team, health professionals and up as far as board level within the provider's umbrella organisation. Whilst occasions on which restraint was used were

recorded in people's care records, some had not been identified as incidents for reporting purposes and so did not appear within the management reports. There were at least three incidents between October and December 2016 where restraint had been recorded in people's care records but had not been reported through the provider's monitoring system. The acting manager told us these all met the criteria for reporting through the provider's management system, and confirmed they had not been reported. The lack of an overview meant the provider could not be sure that appropriate action had been taken and plans put in place to protect people in future.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a health and safety policy and regular checks of the health and safety of the environment were completed. These included gas and electricity safety, including small pieces of electrical equipment, and checks of the water systems and legionella testing (legionella are water-borne bacteria that can cause serious illness). Fire systems were also regularly tested including checks of fire equipment, regular fire drills and ensuring means of escape were accessible and free from obstacles. Easy read guidance on the action to take in the event of a fire was displayed within communal areas of the home. Windows above ground floor level had restrictors in place and radiators were covered to reduce the risk of scalding.

However, on the first day of the inspection we identified a number of hazards that had not been picked up on by the internal health and safety audits. We drew these to the acting manager's attention. On the second day of the inspection the acting manager had taken action on the hazards we had identified to make sure the environment was safe for people who lived at the home.

There were arrangements in place to keep people safe in an emergency. Guidance was available on what action to take in the event of an emergency such as fire, flood or failures of gas or electricity.

Risk assessments and management plans protected people and supported them to maintain their freedom. For example, one person cooked for themselves and risk assessments were in place to identify any hazards associated with this. There were also risk assessments for activities people were involved in outside the home.

People were protected against the risks of potential abuse and neglect. Safeguarding guidance, including contact telephone numbers for external organisations, was displayed in the office. Staff had received training in safeguarding adults and financial abuse. We spoke with staff about safeguarding adults and they understood what action they needed to take if they were concerned or worried about someone.

Peoples' medicines were managed and administered safely. Medicines were stored securely. There were clear instructions for staff in people's medicines administration records (MAR), as well as care plans for each 'as necessary' (PRN) medicine that set out what the medicine was for, how it should be given, the minimum interval between doses and the maximum dose in 24 hours. There were regular checks to ensure staff initialled the MAR each time they administered medicines, that there was sufficient medicine in stock and that the amount was recorded correctly. Staff who administered medicines had training to do so and their competence in handling medicines was checked periodically.

Good

Is the service effective?

Our findings

People were not able to talk to us at length about their care and treatment and what they thought of the staff. A relative spoke positively about the staff and, in the context of staff and manager turnover at the service, expressed the view that the staff "need to be nurtured and supported".

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.

Staff sought people's consent including offering choices before they helped or supported them. We heard staff asking people things, supporting them to make choices for themselves and involving them in decisions about their care. For example, staff discussed with someone what they wanted to eat for lunch and offered them choices in a way that would help them to make a decision.

As far as possible, people made their own decisions about what they wanted to do. One person liked shredding paperwork and we saw that when they sat by the shredding machine staff understood what they wanted to do and helped them. Staff also told us about how they made sure people made their own decisions and that they acted upon them. One staff member said, "I will give plenty of options, you have to listen" and another staff member told us, "They have the right to choose". Staff provided us with information about one person who they had supported with breakfast. They explained how the person communicated their choices and how they understood what the person didn't want to eat.

When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and the least restrictive possible. Some mental capacity assessments and best interests decisions in relation to some aspects of care were in place. However, people's capacity to make other specific decisions had not been assessed and best interest decisions were not in place. In addition, staff had sought consent inappropriately from some family members where they did not have a legal power (such as a lasting power of attorney or Court of Protection deputyship) to make decisions on the individual's behalf. This meant there was a risk people's rights would not be protected and decisions made in their best interests because staff were not fully adhering to the MCA. The acting manager had received their mandatory training in the MCA. However, they had not had the additional training that would have supported them in their management role to ensure that the requirements of the Mental Capacity Act 2005 were met.

We recommend the service seeks training and support from a reputable source to ensure peoples' rights are protected through adherence to the MCA.

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). These safeguards can only be used when there is no other way of supporting a person safely. We looked at whether the service was applying the DoLS

appropriately. The acting manager had made the appropriate applications and where there were conditions attached to an authorisation the acting manager had ensured these were acted upon.

People's needs were met by staff who had access to the training they needed. New staff received an induction and had two weeks of shadowing to make sure they understood their role and how people wanted or needed to be supported. Staff who were new to care work were also undertaking the Care Certificate (this is a national qualification). There was ongoing training in areas such as emergency first aid, fire safety, food hygiene, medicines management, health and safety, infection control, and manual handling. Service specific training such as conflict management, positive behaviour support and sexuality and relationships had also been undertaken. There were some gaps in staff training but the acting manager had a plan in place to rectify this.

Staff told us they felt well supported by the acting manager, whom they said they could approach for advice or guidance at any time. One member of staff said the support they received was, "Brilliant, you can speak to the manager about anything".

According to the provider's policy, staff should have had regular supervision meetings, at least every six to eight weeks. The acting manager acknowledged this had fallen behind, although their supervision plan showed that most staff had had a supervision meeting since the beginning of February 2017.

People had diets rich in foods they liked and which met their dietary needs. Staff promoted healthy eating and encouraged people to have a varied diet, although one person preferred a more limited range of food. The staff were aware of people's dietary needs and preferences, which were clearly recorded in their care plans. A relative commented that their family member had a balanced diet and that staff knew exactly what people liked to eat. One person had a safe swallow plan devised by a speech and language therapist, to help reduce their risk of choking. People were encouraged to be involved in shopping and preparing meals.

People's care records showed relevant health and social care professionals were involved with their care. Care plans were in place to meet people's needs in these areas and were regularly reviewed. People had a health action plan which described the support they needed to stay healthy. People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

Good

Is the service caring?

Our findings

People were not able to tell us about whether the staff were caring and treated them with dignity and respect. However, all of the interactions we observed were caring and respectful. A relative spoke highly of the caring approach of the staff and said of the service, "It feels like his home".

People's dignity was respected by staff, who treated them with kindness and compassion. People approached staff freely to spend time with them or gain assistance, and were visibly happy in their company. They were positive and interested in what people were doing and during our discussions staff demonstrated a genuine concern about people's welfare and happiness. A staff member commented on the caring nature of the home telling us, "The atmosphere is really nice. I look forward to coming to work".

People moved freely around the home and did what they wanted to do. One person liked magazines and they were looking at a catalogue. They were smiling and looked happy. Later we saw them using a vacuum cleaner and accessing their electronic tablet.

People's records contained comprehensive information about their life stories, strengths, likes and dislikes, and communication styles. Staff knew the people they were supporting well. They understood people's individual communication skills, abilities and preferences. The people living at the service experienced some difficulties with communication and one of them did not speak or use a recognised sign language. Nonetheless, staff recognised what people were communicating through their gestures and other non-verbal communication, and supported them accordingly.

Staff knew about things people found difficult and how changes in daily routines affected them. For example, on the second day of the inspection, someone appeared anxious and upset. The staff had already recognised this and identified a possible cause. They discussed between themselves how they would support the person to manage what they were worrying about. This worked and the person later appeared happier and calmer.

Staff had received training in equality and diversity. They knew, understood and responded to each person's diverse cultural and spiritual needs in a caring and compassionate way. For example, for one person it was important to them to go to church each week. This was reflected in their care plan, which gave detail about how staff needed to support the person during services.

Communal areas and bedrooms within the home were decorated and furnished in a homely way, with pictures of activities people had enjoyed or that reflected their interests. A relative of someone who was unable to give detail about their preferences said their family member's rooms had been redecorated in consultation with them: "They don't do anything without us".

People were encouraged and supported to have regular contact with their families, and to receive visits at any time they wished.

Good

Is the service responsive?

Our findings

People were not able or did not wish to tell us about their experiences of care. However, a relative spoke highly of the care and support their family member received, and told us, "We would not want him to move".

People's needs were kept under review and each person had thorough care plans that set out their daily routines and the assistance they required. The people living at the service had been there a number of years. They and their relatives were involved in developing and reviewing their care and support plans, which were up to date. Care records included a one page profile of the person, summarising their needs and preferences. Assessments and care plans were individualised and written positively, in a way that focused on people's strengths. They covered areas such as washing, bathing, dressing and other personal care, maintaining relationships, communicating, making decisions, managing emotions, managing behaviour that challenges, spirituality, accessing the community and activities. One of the assessments we saw addressed the person's sexuality in a way that promoted their human rights.

People got the care and support they needed. Staff had a good understanding of people's care plans and supported them accordingly.

The acting manager believed passionately that people with a learning disability should be involved and visible in their local community and actively promoted this. People were encouraged to access the community regularly, with the support they needed to help them stay safe and confident. People went out and about with staff during the inspection. Care records reflected regular trips out for various activities people enjoyed and valued, such as going to football matches, church services, sports, the pub and for walks. One person planned and went on regular trips in connection with a hobby.

People were supported to develop independent living skills and be involved in daily living tasks. For example, people were encouraged to be present when their meals were being prepared; one person did their own food shopping and cooking. When we arrived for the inspection, someone came with staff to answer the door.

There was a complaints policy and information about making a complaint was displayed in communal areas of the home. We looked at the complaints made in the 12 months preceding this inspection. These complaints preceded the acting manager commencing in post. For two of the complaints the acting manager was unable to access a record of an investigation or outcome. The acting manager was aware of these complaints and understood they had been investigated. The acting manager acknowledged there was scope for staff to be more aware of what they should do if they received a complaint. They told us, "It's important that staff know how to deal with a complaint. It needs to be more visible and accessible to everybody". This was an area for improvement.

We recommend the provider reviews their process for recording and learning from complaints.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have effective systems in place to monitor and improve the quality of care and support that people received. Quality audits were completed on a variety of aspects of the service, such as the environment, infection control, the home vehicle and a range of monthly quality audits linked to the regulations. There were also other audits related to the buildings and equipment safety, such as bedroom checks, and first aid kit and kitchen audits. However, these audits were not fully accurate and therefore did not identify actions staff could take to improve the experiences of people living at the home. They had not identified some of the issues we found during the inspection. For example, items in a first aid box were past their expiry date, an extractor fan had not been cleaned, dried foodstuffs were stored in opened packaging rather than sealed containers, the framework on a person's specialist seat had not been cleaned, and a tall shelving unit was coming adrift from the wall. Some of these matters were not covered routinely in health and safety checks. The March 2017 direct support audit wrongly identified the number of accidents and incidents and complaints made about the service. The health and safety audit undertaken in December 2016 stated the home was 'Maintaining a good standard', and the quality and safety audit tool undertaken in May 2016 identified the home as 'outstanding'. Where audits had recognised shortfalls and staff had requested action, this had not always happened. Following the inspection, the provider advised us that quality audits were completed six monthly, most recently in December 2016, at which point the issues we highlighted were not evident.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager had notified CQC about some significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe. However, CQC had not been notified, as it should have been, about one person who was subject to DoLS, and about a police incident. The regulations require DoLS and police incidents, amongst other significant events, to be notified.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the time of the inspection, the registered manager was no longer working at the service and had applied to cancel their registration. An existing member of staff was acting manager and a new manager had been recruited but had yet to start work. The relative we spoke with was aware of this and commented, "[Acting manager] stepped up to the plate very, very well". The acting manager had been supported by regular visits from their line manager, who was not based locally.

People and those important to them had opportunities to feed back their views about the home and quality of the service they received. A relative told us they felt very able to express concerns to senior and executive management as well as management at the home. They remarked that a senior manager "went out of [their] way to come and see us at home" to avoid interrupting their visit to their family member at the service. They said of the acting manager and staff, "I do find them approachable with practicalities, they listen and they change". Staff checked with people through a variety of ways that they were happy with the support they

received. Staff told us one person was, "Very good at showing us what [they] enjoy". They described how another person used non-verbal language to indicate whether they were happy with things such as their meals, activities or choice of support worker. The acting manager said, "[The person] does have preferred members of staff. Staff take note so [they] are comfortable with who is supporting [the person]".

Regular staff meetings were held, including formal meetings monthly and daily handovers. These gave staff an opportunity to find out how people were, discuss any changes in their support needs and ask questions or raise concerns. Activities for people, staff training and health and safety were also discussed.

Staff had received training in information governance, person centred planning and recording and documentation.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of all incidents and occurrences that affected the health, safety and welfare of people who use the service. This included an incident that was reported to the police, and an authorisation under the Deprivation of Liberty Safeguards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been operated effectively to ensure compliance with the Regulations. The system for monitoring accidents and incidents at the provider's level was not robust, and did not ensure trends or patterns were identified to reduce the risk of a reoccurrence. Whilst occasions on which restraint was used were recorded in people's care records, they had not been identified as incidents for reporting purposes. The absence of an overview meant the provider could not be sure that appropriate action had been taken and plans put in place to protect people in future. There were shortcomings in the monitoring of the quality of care and support. Audits were not fully accurate and had not identified some of the issues found during the inspection. Where audits had recognised shortfalls and staff had requested action, this had not always happened.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

Staff recruitment files did not all contain evidence that the provider had assured themselves of the staff members' satisfactory conduct in previous health or social care employment. The recruitment and selection procedures had not operated effectively to ensure references were obtained from the most recent employer in health or social care.