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The Willows Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 18 April 2018 and was unannounced. At our previous inspection in February 2016 we had no concerns in the quality of the service and had rated the service as good. At this inspection we found that the service was not consistently safe, effective, caring, responsive or well led. We found one breach of regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of this report.

The Willows is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection 10 people were using the service.

There was a registered manager in post. 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.

People were not always receiving care that was safe and that met their assessed needs. Staffing levels had not been reviewed to ensure they met people's current care needs.

People's assessed needs were not always being met. Staff had not received all the training they required to be able to fulfil their roles effectively and health care advice and support was not always gained in a timely manner.

People did not always receive dignified care and their right to privacy was not always respected and prompt action had not been taken to ensure that people were cared for in a safe way.

The registered manager knew the local safeguarding procedures and new staff were employed using safe recruitment procedures.

People's medicines were stored and administered safely and people were protected from the spread of infection.

People were supported to eat and drink sufficient amounts to remain healthy.

The principles of the Mental Capacity Act were followed to ensure that people who lacked mental capacity were consenting to their care and support.

The environment had been adapted to meet the needs of people who used the service and people where able were able to make choices about their daily routines.

There was a complaints procedure and people felt able to raise concerns and people's end of life wishes were gained.

The registered manager and provider demonstrated a caring attitude towards people they cared for and there were quality monitoring systems in place.

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 consistently safe.

People were not always receiving care that was safe and that met their assessed needs.

Staffing levels had not been reviewed to ensure they met people's current care needs.

The registered manager knew the local safeguarding procedures.

People's medicines were stored and administered safely.

New staff were employed using safe recruitment procedures.

People were protected from the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's assessed needs were not always being met.

Staff had not received all the training they required to be able to fulfil their roles effectively.

Health care advice and support was not always gained in a timely manner.

People's nutritional needs were met.

The principles of the MCA were followed to ensure that people were consenting to their care and support.

The environment had been adapted to meet the needs of people who used the service.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always receive dignified care.

People's right to privacy was not always respected.

People where able were able to make choices about their daily routines.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always receiving care that met their assessed needs.

There was a complaints procedure and people felt able to raise concerns.

People's end of life wishes were gained.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Prompt action had not been taken to ensure that people were cared for in a safe way.

Staff were not always receiving the training they required to be able to fulfil the tasks being asked of them.

Staffing levels had not been assessed and agreed dependent on people's individual needs.

The registered manager and provider demonstrated a caring attitude towards people they cared for.

There were quality monitoring systems in place.

The Willows Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 inspection took place on 18 April 2018 and was unannounced. It was undertaken by one inspector.

We looked at the provider's provider information return (PIR) and at the notifications the registered manager had sent us notifying us of significant incidents.

We spoke with one person who used the service and observed other's care. We spoke with two members of staff, the registered manager and provider. We spoke a social care professional. We used our short observational framework for inspection (SOFI) tool to help us see what people's experiences were like. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time and whether they had positive experiences. This included looking at the support that was given to them by the staff.

We looked at the care records for three people who used the service. We looked at the way in which people's medicines were stored and managed. We looked at the systems the provider had in place to monitor and improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we had no concerns in the safety of the service and had rated this area as good. At this inspection we found that people were not always receiving care that was safe and there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had previously been made aware by the local authority that one person who became anxious and aggressive at times was being held by staff when they were supporting them with their personal care. Although the registered manager had put a risk assessment in place instructing staff how to support the person at these times, staff had not received training to be able hold people safely. Training had been arranged and booked. However, we saw records that showed that this person was still being held before the training had taken place. We also saw records that this person had some unexplained bruising. The registered manager could not be sure that this bruising had not been caused by the unsafe holding of the person. The registered manager took action to stop staff from holding the person on the day of the inspection.

We were informed that one person had been assessed by the local authority several months ago as requiring nursing care. The registered manager told us that staff were not able to support the person to move in a safe way as there was not enough room for a hoist and equipment in the person's bedroom. Staff were having to support this person to move in an unsafe way which put the person and the staff at risk of harm. During the inspection we discussed this person with the local authority and they told us that they knew the person's needs were not being met at the service and that they had been trying to find a more suitable placement. The registered manager had sought advice from the local authority and involved an occupational health therapist. However, no action had been taken by the registered manager to minimise the harm to the person through unsafe moving and handling in the form of a risk assessment or seeking professional health care advice. This put this person at risk of harm due to them receiving unsafe care and support.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw other examples of where the registered manager had acted to reduce the risk of harm to people following an accident. For example, one person had fallen and injured themselves and they now had a sensor mat in place to alert staff if they were mobilising alone in their bedroom. Another person had fell in their bedroom and knocked their head on a piece of furniture. Following the accident the furniture was moved to minimise the risk of potential harm occurring again.

During the inspection the registered manager referred the two concerns reported on above to the local safeguarding authority for investigation as they recognised the issues may constitute abuse in the form of poor and unsafe practises. We had been notified of other incidents that the registered manager had reported for investigation to the safeguarding authority. This showed that the registered manager knew the local safeguarding procedures.

We observed people's care throughout the day and saw there were times when people were left unsupervised in the lounge area. We saw that one person was standing over other people and one person looked intimidated by this. We found that one person was being cared for in bed and required two staff to care for them and other people also required two staff to support them with their personal care needs. We discussed this with the registered manager as there were times when they were not on duty when only two staff were available to meet people's needs and administer medication and ensure the smooth running of the service. A member of staff told us that at these times it was difficult to support people in a timely way. The registered manager told us that they recognised that the needs of some of the people had changed and they were requiring more staff support. They assured us that they would assess people's dependency needs and ensure that staffing levels were safe to meet people's current care needs.

New staff were employed through safe recruitment procedures. The registered manager carried out pre-employment checks prior to offering potential new staff a job. Pre-employment checks would include the completion of disclosure and barring service (DBS) checks. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant.

We looked at the way that people's medicines were stored and administered. People's medicines were stored and administered safely. People's medicine was kept in a locked trolley in a clinical room. Staff we spoke with confirmed they had received comprehensive training in the administration of medicines. We observed medication being administered and saw it was completed in a safe way. People had clear medication care plans which informed staff how people liked to take their medication dependent on their personal preferences.

We observed that staff followed safe infection control procedures whilst caring for people. Staff used gloves and there was hand wash available throughout the service for staff and visitors to use. The provider employed domestic staff and we saw that the environment was clean throughout. Soiled clothes and bodily fluids were handled safely with laundry bags that separated the wash loads. This meant that people were being protected from the spread of infection.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we had found that the service was effective and had rated this area as good. At this inspection we had some concerns about the effectiveness of the service and found that this area requires improvement.

People's needs were assessed regularly and the registered manager involved other agencies when people's needs had changed. However, we found that two people's assessed needs were not being met in a safe and effective way. One person had been assessed as needing nursing care and another person required supporting with their challenging behaviour and we found that staff were unable to care for these people in a safe way due to a lack of training and specialist equipment. This meant that these people were not receiving care that was safe and effective.

People mostly received health care advice and support when they became unwell. However we saw it was recorded on a handover sheet that the night staff had reported to the day staff that one person had become unwell in the night. However, they had taken no action at the time to call for medical assistance and had left them until the morning to inform the day staff. The day staff did seek prompt medical assistance as the person was showing signs of a serious condition. We discussed this incident with the registered manager who informed us that the night staff involved in the incident had been formally spoken to about this.

Staff told us they felt supported by the registered manager and we saw that they received formal supervision and some training. However, although training had been planned, at the time of the inspection they had not received training in how to hold people safely and this left one person at risk of receiving unsafe care. Staff were being asked to support one person with their mobility by using unsafe care practises. This left the staff and people at risk of harm due to a lack of training and support.

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. Some people who used the service required support to make decisions and to consent to their care, treatment and support. We saw that people's capacity to consent had been assessed. Some people had signed their own care plans consenting to their care other people were supported by their relatives or representatives to consent to their care.

We saw that most people had been referred to the local authority for a Deprivation of Liberty Safeguards (DoLS) authorisation as they were at times being restricted of their liberty, for example not being able to go out alone. The Deprivation of Liberty Safeguards is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw the registered manager had followed the process correctly.

People were supported to eat and drink sufficient amounts to remain healthy. One person told us: "The food

is good". We saw people had a choice of food and drink and that when they required support to eat or drink this was given to them. Some people required a softer diet or specialist cutlery and crockery and we saw that it was available and being used by people. People's food preferences were recorded and dietary advice was sought if people were noted to have had lost weight.

The environment was adapted to meet people's needs. It was 'dementia friendly' with clear signage, doors painted block colours to show they were doors, bright toilet seats to enable people to see them. Every effort had been made to personalise and adapt the service to meet people's needs in relation to their dementia. There were raised toilet seats and assisted bathing facilities for people with mobility conditions. There was a stair lift and two lounge areas so people could choose where they spent their time.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had no concerns in the way that people were cared for and had rated this area as good. At this inspection we found some concerns that people were not always being cared for in a dignified way.

We found although staff were kind and caring in their interactions with people, some of their care practises did not promote people's dignity. For example, one person was being held when having their personal care needs met as they became distressed, however staff had not been trained to do this and the practise had not been assessed as appropriate. Another person was being supported to move in an undignified way as staff were not following safe moving and handling guidance. We discussed these concerns with the registered manager and provider and they told us that they recognised that the care these people were receiving was not appropriate. They told us that they cared about these people and had been concerned that they may not be able to remain at the service. They told us they were doing everything they could to keep them in the place they knew as home. However, this meant that these people's care was not safe and meeting their needs.

We saw that people's bedroom doors had signs on them which stated that staff should 'knock and wait before entering'. However we saw three occasions where two members of staff just walked into people's bedrooms without knocking whilst they were still in bed. This did not respect people's right to privacy.

One person told us: "It's like home here, the staff are marvellous, they are a good bunch of people. I have no wish to move as it can't get any better". We observed that staff were kind and caring to people and spoke to people in a patient and compassionate way. We observed one person asking a member of staff to scratch their back. We saw that the staff member did this and it brought much relief to the person and they laughed and thanked the staff member.

Most people who used the service were living with dementia. We saw that staff interacted with people in a way in which they understood offering them choices about what they wanted to do, where they wished to go and what they would like to eat. We saw that some people liked a lie in bed and this was respected. The registered manager told us that advocacy services were available for people if they required them.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns in the responsiveness of the service and had rated this area as good. At this inspection we had concerns that the service was not always responsive to people's individual assessed needs.

Prior to their admission, people's needs were assessed with them and their representatives to ensure that the service could meet them. We saw within the assessment process there was a booklet called 'This is me' which would help inform staff of people's past interests, likes, dislikes and preferences including their sexual orientation, cultural and religious needs. We saw that people's bathing preferences and food preferences to people's shoe size were recorded to ensure that every detail about people's personal needs were recorded.

People's needs were regularly reviewed by the registered manager and they contacted external agencies for advice when people's needs had changed. However we found that when their needs changed the care they received did not always change to meet those needs. Some people's needs had become more complex in relation to their behaviour and mobility. Although the registered manager had updated these people's care plans the care being delivered was not responsive or appropriate to be able to meet these people's needs.

Most people who used the service were living with dementia and required support of different levels to negotiate around their home and help them orientate to time and place. We saw that the registered manager had followed good practise guidelines in caring for people with dementia. The environment was 'dementia friendly' with clear signage, doors painted block colours to show they were doors, bright toilet seats to enable people to see them.

There was a range of hobbies and activities available to people. There were items of memorabilia and reminiscence around the home such as clothes from people's era, records, handbags and hats. Each person had a memory box on their bedroom door with items within them that would remind them of where their room was.

The provider had a complaints procedure. The registered manager told us that they had received no complaints since the last inspection. One person who used the service told us: "If I needed anything I would speak to any of the staff.

People's end of life wishes were gained and recorded in a care plan. The information within the care plan recorded whether people wished to be buried or cremated and any other individual preferences. The registered manager told us that they liaised with other health care agencies when caring for people at the end of their life, for example, the Douglas Macmillan nurses.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection we had no concerns in the how the service was led and had rated this area as good. At this inspection we found that the service required improvement throughout.

The provider and registered manager demonstrated a caring nature towards the people they provided care for. However, their kindness had meant that they were not always able to make professional judgments about whether they were meeting people's needs in a safe and effective way.

We found that two people's needs had changed and the care they were receiving was not safe or effective. The registered manager had been made aware by the local authority that two people's needs were not being safely met at the service. However, the care these people received had not changed and they were still being cared for in an unsafe way. The registered manager had took action to seek advice and support from other agencies to ensure that these people were receiving care in a safe and effective way. However the issues had continued and the registered manager had not took prompt action to ensure people were safe by alerting the local safeguarding authority. The registered manager took action on the day of the inspection by contacting the commissioners of these people's service and raising safeguarding referrals for them.

We discussed with the registered manager how they assessed safe staffing levels and ensured there were sufficient staff at all times to meet the needs of people who used the service. They had not considered that some people's needs had changed and that their dependency levels may mean that they now required more staff. They told us that they would assess people's dependency needs to ensure that the current levels of staff were safe and that going forward that more staff would be recruited when necessary.

Staff felt supported by and liked the registered manager and provider. However they were not always receiving the training they required to fulfil the care tasks being asked of them. They were carrying out care practises that potentially could cause harm to them and the people they were caring for.

The registered manager carried out a number of quality audits including, resident quality surveys. We saw that the feedback from these were positive so no action to improve had been necessary.

The registered manager knew their responsibilities in relation to their registration with us. They had notified us of significant events and their previous inspection rating was on display

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care that was safe.

The enforcement action we took:

We served a warning notice.