St. Martin's Care Limited

Willow Green 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?	**Inadequate**

Summary of findings

Overall summary

About the service
Willow Green Care Home is a care home providing accommodation and nursing and personal care for up to 63 people. At the time of inspection, there were 46 people living at the home.

People's experience of using this service and what we found
During the inspection we found the registered provider was in breach of regulations in relation to person-centred care; consent; safe care and treatment; and good governance.

The service had a registered manager at the time of our inspection but they were on leave. They resigned from this role and the service shortly after our inspection visit.

Work was required to address issues identified within people's individual risk assessments to ensure they included how staff should care for people to keep them safe.

Medicines were managed safely at the home however some areas required improvement. We could not be assured that incidents that should have been reported and recorded as safeguarding events had been.

Staff recruitment was not always safe but we saw the nominated individual took immediate action to ensure one staff member without a reference did not return to the home until this had been resolved. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We received mixed views about the levels of staffing within the home, however most people said their care needs were met. We made a recommendation about this.

Records relating to fire safety were incorrect and incomplete, immediately following our inspection this was addressed by the service. Governance arrangements in the service were poor. Audits carried out in the service did not identify the deficits we found.

Some people's care plans included incomplete or incorrect mental capacity assessments. We could not verify from records who had deprivation of liberty safeguard (DoLS) authorisations in place.

Care plans did not guide staff on how to deliver person centred care. They were brief and task based. We did not see specific end of life plans for people.

Supervisions had been in place for staff but these were not well completed. Staff had received training to support them in their role.

People were provided with a range of food and drinks to help them to maintain a healthy balanced diet. Feedback from people about the quality of the food was mixed.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not support this practice.

Most people told us they felt safe living at the service. Staff we spoke with knew people well.

People were supported where necessary, by staff to access the community. People were supported to take part in a range of activities within the home by a motivated and innovative activity co-ordinator.

Staff members had access to regular staff and handover meetings.

The nominated individual acknowledged work was required to address issues which had been identified prior to, and during the inspection. They had created an action plan for the home, the progress of which was monitored on a weekly basis. Additional management support had also been brought into the home following the resignation of the registered manager.

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

Rating at last inspection
The last rating for this service was good (published 28 November 2018).

Why we inspected
We undertook this initially as a targeted inspection to check on multiple concerns raised by the local authority safeguarding team.

We widened the inspection to a comprehensive inspection after the first visit to assess whether there were any additional risks to people using the service.

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

Enforcement
We have identified breaches in relation to complaints, record keeping, good governance, person centred care and keeping people safe. 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 from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider, local authority and Clinical Commissioning Group (CCG) to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Willow Green Care Home

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.

Inspection team
The inspection team consisted of two inspectors, a medicines inspector and one specialist advisor (nurse) on 14 January 2020. On 15 January 2020 the inspection team consisted of one inspector.

Service and service type
Willow Green 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 our inspection the service had a registered manager. However, they resigned from their role and left the service shortly after our inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information available to us since the last inspection. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from commissioners and professionals who work with the service, including the local authority safeguarding adult's team. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We also contacted Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection
We spoke with the nominated individual, two managers who worked at other services owned by the provider, two nurses, two senior carer staff and four members of staff. We also spoke with six people who lived at the home and five visiting relatives.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff personnel files and records related to the management of the service.

After the inspection
We continued to speak with the management team to discuss and confirm the inspection findings.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management
• Safeguarding issues were not dealt with appropriately. A staff member's concerns about alleged abuse had not been fully investigated or alerted to the local authority safeguarding team. The concern had been recorded as a complaint and this also had not been properly investigated. One senior care staff also told us they were, "Not always confident of a response" if they reported a safeguarding concern to the management team.
• The provider had policies and procedures to deal with allegations of abuse but these had not been followed consistently.

Safeguarding systems were not robust. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Staff completed safeguarding training and understood how to report any concerns they had.

Using medicines safely
• Medicines were not always managed safely. Clinic rooms were well organised with temperature monitoring in place. Equipment used to support medicines administration was not always clean, one clinic room floor required cleaning and room temperatures in one room were consistently at the maximum recommended temperature.
• Handwritten Medicines administration records (MARs) were not always signed by a second person in line with the homes policy and national best practice. We found one example where transcribed entries were not accurate so there was risk this medicine would not be administered safely.
• Records for topical preparations such as creams were not always accurate and sufficient stocks of creams were not available. Topical MAR chart records did not always contain the same information as the printed MARs. Application records were not always completed, and date of opening was not always recorded in line with the homes policy. Therefore, we could not be assured that topical medicines were being used as prescribed.
• Audits were being carried out by management however the audit process lacked structure and oversight. For the audits that had been completed actions were not monitored for completion and audits were not completed as per the homes policy as they were not completed weekly.

Medication systems were not always monitored effectively. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The service did not complete robust recruitment checks. Recruitment records showed that appropriate references had not always been sought from the person's previous employer. Three of the four files viewed did not have the appropriate references. The nominated individual took immediate action to ensure these references were sought and prevented one staff from coming to work until this was in place.

Records relating to staff were not well maintained. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We received mixed feedback from people about staffing levels at the service. One staff said, "If the senior is busy it leaves one care staff on this unit and several people have 2:1 care needs." A relative said, "I have had to support [Name] to the toilet as there wasn't any staff around."

We have made a recommendation that the service reviews the staffing numbers and deployment across the service to ensure staffing levels are safe and effective.

Assessing risk, safety monitoring and management;
• Two people who had gone significant time without receiving medication they were prescribed for. One person told us, "I wondered why I felt funny." The other person had gone for six days without a pain relieving patch.
• Staff did not always follow best practice guidance or advice when supporting people. For example, for people who were fed via a PEG tube there were no health specific risk assessments in place and information on how to manage displacement of the tube and potential contamination from utensils used in preparing the feed.
• One person 's pressure relieving mattress was not set to the setting stated in their care plan. The person told us that their mattress was, "Flat at times and didn't appear to be working." We spoke with the senior carer on duty who told us they would action this immediately.
• We observed staff administer food thickener at the incorrect dosage as detailed in the person's assessment from a Speech and Language Therapist. We raised this immediately with the nominated individual to ensure all staff were aware of correct consistency.
• The premises were not always safe for people living at the home. Pull cords were not fully accessible in all bedrooms and communal areas although this was immediately addressed by the management of the service.

Preventing and controlling infection
• Infection control measures were not effective. On the Bluebell unit in a shower room, we found a shower chair with rusty wheels and a dirty shower seat. There was also a clinical waste bin with a dirty lid with no foot pedal meaning this was an infection control risk. On another unit there was a dirty toilet brush and flooring lifting away in an assisted bathroom.

The provider failed to ensure risks to people's health, safety and welfare were fully mitigated or regularly reviewed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.
• Two people did not have protective bedrail bumpers in place or risk assessment to state why these were not present.

• The service did not comply with fire safety. Fire records did not demonstrate that actions described in the fire risk assessment had been carried out. Only four of the 12 night staff had been involved in a fire drill.
• The grab file that contained information about people's personal emergency evacuation plans for the

emergency services was out of date. There were only 40 names in the file when there were 46 people resident in the home. The management team in the home addressed this immediately and it was amended by the second day of our inspection.

The provider failed to ensure risks to people's health, safety and welfare were fully mitigated or regularly reviewed. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The provider was not always effective in learning from incidents. This was because not all incidents at the service had been recorded and investigated.

The provider did not assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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.
• The service did not work within the principles of the MCA. From records held at the home, we could not determine who was lawfully deprived of their liberty or not. A manager from another service had to contact the authorising body to confirm who had been deprived of their liberty.
• Consent forms were signed by people without the legal authority to do so. For one person who had mental capacity the consent forms for care and support were signed by a relative and another person's consent forms were not completed.
• Best interest decisions showed some had only been signed by a senior care staff. This should be a decision made by a multi-disciplinary team.

The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Supporting people to eat and drink enough to maintain a balanced diet
• Tools to assess the risk of malnutrition for people were not always well completed.
• Food and fluid charts were not always well completed
• People told us meals were "repetitive." However we saw people were given choices throughout our visit and there was a resident meeting held where people talked about menus.
• Care plans included people's preferences, any special dietary requirements and showed staff worked with

other health professionals such as speech and language therapists (SALT) to minimise risks for people.

The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Staff did not always follow best practice guidance or advice when supporting people. For example, for people who were fed via a PEG tube there were no health specific risk assessments in place and information on how to manage displacement of the tube and potential contamination from utensils used in preparing the feed.
• People's needs were assessed before they moved into the home to make sure staff could provide the care and support they needed.

The provider did not maintain an accurate, complete and contemporaneous record in respect of each service user. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Adapting service, design, decoration to meet people's needs
• The service décor did not promote appropriate signage for people with cognitive and visual impairments. Handrails weren't highlighted in a separate colour and some information was in small text. One person said they had bruising from bumping into handrails and said "How can I join in activities if I cant' see what's on the activities board."

Staff support: induction, training, skills and experience
• The training matrix identified some staff had not undertaken refresher training in areas the provider considered mandatory such as safe handling of medicines. In a provider audit in October 2019, the service had been below the local authority's compliance level of 85%.
• Staff told us they received supervisions but records we viewed lacked meaningful discussion and those of senior staff were sparse. Where staff raised issues in this forum there was no evidence of actions taken by the management.

Staff working with other agencies to provide consistent, effective, timely care
• The service worked with external professionals to support and maintain people's health, for example GPs and specialist nurses.
• Staff supported people to attend health appointments.

Supporting people to live healthier lives, access healthcare services and support
• Referrals were made to healthcare professionals such as dieticians and dentists where appropriate in a timely manner.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
• We observed care staff were respectful of people. During both days of the inspection we observed care staff knocking on bedroom doors and asking permission to enter.
• Some investigations were ongoing where allegations were staff had not always treated people with dignity and respect.
• People's independence was not always promoted as in one area of the home, call bells were tied out of reach. This was addressed immediately.
• We received mixed views from people's relatives regarding the care at the home. Some were very happy with the standard of care provided whilst other relatives told us their family had received poor care.

Ensuring people are well treated and supported; respecting equality and diversity
• People's care records were not always person centred or legible, meaning staff may not know how to care for people in the way they wanted. However, we found by speaking to staff that they knew people well.
• People were positive about the support from staff. One person said, "I am happy to be cared for by the staff here."
• There were equality and diversity policies to help ensure people were treated fairly.

Supporting people to express their views and be involved in making decisions about their care
• There were regular resident and relative meetings at the home where people's views were sought.
• One person had a resident ambassador role and told us they enjoyed making sure people were happy at the home. They said, "I have raised issues with the management and found them responsive."
• There was information about advocacy services displayed within the home.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
• There was no clear record of complaints at the service. We found complaints were not consistently acknowledged, investigated or the outcome shared with the complainant.
• One incident in the complaint file was a clear safeguarding concern of a staff member whistleblowing. This had not been safeguarded by the management team. This was immediately safeguarded when we raised this with the service.
• People and relatives had access to the complaint's procedure. People we spoke to did not have any concerns at the time of inspection. Following our inspection we received two complaints from relatives who said their complaints had not been actioned by the home.
• There was no learning recorded from complaint outcomes that was shared with the staff team.

The provider did not have an effective system for identifying, receiving, recording, handling and responding to complaints. This was a breach of regulation 16 (Receiving and acting on complaints) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Staff did not always have information to follow to make sure people's needs were fully met, due to care plans not being fully completed for everyone and some plans could not be read as they weren't legible.
• People had assessments for their care needs but these were not always used to plan care and support that was individual to them. Care plans were brief and task based. One plan read, "[Name] has a PEG inserted. All medication to be administered via the tube." Some care plans were not legible.
• People may not receive consistent, planned care and support if they had to move to a different service. We did not see a system in place for people when they had to transfer between services, for example if they had to go into hospital or be moved to another service.
• Reviews of people's care needs were not always recorded, and in some instances, changes to people's needs could not be read.
• Handover records contained a photograph of the person, however there was no overview of people's health conditions and support needs. As there was a high use of agency nurses, this meant key information about people may not be available.

Care plans did not meet people's needs or reflect their preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

• Not all people had correct and up to date information in place relating to emergency support. For one person their DNACPR and emergency healthcare plan stated, "Dementia, diabetic", whereas the person was not living with dementia nor was diagnosed with diabetes. We discussed this with the senior carer who told us they would contact the GP surgery to rectify this.
• End of life plans were not in place for people to record the support they wanted at this stage of their life.

Care plans did not meet people's needs or reflect their preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• Care plans contained limited information on how people could be helped to communicate effectively.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• The activity co-ordinator was highly motivated and had developed exciting activities and positive community links to make sure people felt part of their community.
• We observed the activities co-ordinator carrying out a knit and natter with people. One person told us, "I am the home's ambassador so I invite people to get involved and encourage them. We have loads going on."
• The home had involved a local school and their Duke of Edinburgh award students helped the home's choir and attended other events put on by the home.
• People were supported to maintain relationships that were important to them and encouraged to follow their cultural and religious beliefs.

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 good. At this inspection this key question has now deteriorated to inadequate. 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
• The service was not well-led. Systems in place to monitor the performance of the service had failed to find the deficits identified by CQC and other professionals who had raised safeguarding alerts. The lack of leadership and support within the home over previous months had impacted on the overall governance and oversight within the home. For example; complaints were not addressed and records relating to depriving people of their liberty were chaotic.
• There was a reactive culture in the home which did not promote an open and person-centred approach.
• The registered manager was on leave but following our inspection we received notification of their resignation from the service. The provider had already put additional management resources into the home.
• The provider had not always notified CQC of incidents in line with regulations and their legal responsibilities. We are dealing with this outside of the inspection process.

The provider did not have systems or processes in place to assess, monitor and improve the quality and safety of the services. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Working in partnership with others; Continuous learning and improving care
• Staff failed to identify areas of people's care where working in partnership with other professionals would have enhanced people's health and well-being. People remained without key medicines and creams and some proactive working with the GP and pharmacy may have corrected this.
• We found incidents that should have been reported as safeguarding concerns in records and from reviews of care carried out by professionals. The current management team addressed this promptly.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were given the opportunity to provide feedback and discuss aspects of the service. There were regular resident meetings and relatives could attend. One person told us, "I can tell them if I am not happy with anything."
• Surveys were carried out with people to explore improvements to the service, for example menu choices available.
• Staff told us there were regular team meetings and they could provide feedback.
• Staff views were mixed about the management of the service. Some staff told us they didn't feel supported

whereas others stated they had confidence in the provider and the leaders at the home.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's care and treatment did not always reflect their needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People were not always protected from receiving unsafe care and treatment and risk of avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints
Treatment of disease, disorder or injury	Complaints were not identified, recorded, investigated and responded to.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place were not effective in assessing and monitoring the quality and safety of the service. Records were not accurate or complete.

The enforcement action we took:

Warning notice