Hexon Limited

The Willows

Inspection report

Bridlington Road
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Tel: 01262470217

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29 June 2016

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 26 January 2016. We identified two breaches of Regulation in respect of Regulation 18 (Registration Regulations 2009) Notifications of other incidents and Regulation 12 (Health and Social Care Act) Safe care and treatment.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 29 June 2016 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Willows on our website at www.cqc.org.uk.

The home is registered to provide accommodation for up to 33 older people who require assistance with personal care, some of whom may be living with dementia. On the day of the inspection there were 27 people living at the home, including two people who were having respite care. The home is situated in the centre of the village of Burton Fleming, close to the town of Bridlington, in the East Riding of Yorkshire. It is also close to the county of North Yorkshire. The general care unit and the dementia care unit are staffed separately.

The registered provider is required to have a registered manager in post and on the day of the inspection the manager who was employed at the home was registered with the Care Quality Commission (CQC). 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.

At our focused inspection on 29 June 2016 we found that the registered provider had followed their plan in respect of the safety of the premises. We toured the premises and saw that the flooring identified as a trip hazard had been replaced. We did not see any other flooring that created a trip hazard. The bed we saw that had a loose headboard had been replaced. A chain across one person's bedroom door had been replaced with a gate; this was easy to open in the event of an emergency but provided a safe way of deterring people from entering the person's bedroom. This reduced the risk of an accident occurring.

We saw that robust systems had been introduced to monitor the safety of the premises and equipment, and that any concerns identified had been promptly dealt with. This included checks on the safety of beds and flooring. We saw these changes resulted in the registered provider meeting the breach of Regulation in respect of the safety of the premises.

At the inspection on 29 June 2016 we found that the registered manager had followed their plan in respect of the submission of some notifications. Since the previous inspection in January 2016 we had received notifications from the registered manager in respect of deaths, serious injuries, safeguarding and events that

stopped the service. However, there was also a legal requirement to submit notifications when DoLS applications had been authorised by the local authority. The registered manager was not aware of this and, although some DoLS applications had been authorised, no notifications had been submitted to CQC.

This was a continued breach of Regulation 18 (Registration Regulations 2009) Notifications of other incidents. We are addressing this breach with the registered provider.

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 safe.

The premises were well maintained and there were robust systems in place to monitor the ongoing safety of the premises and equipment. This protected people from the risk of harm.

This meant that the provider was now meeting legal requirements. Whilst improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for Safe at the next comprehensive inspection.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager had submitted appropriate notifications in respect of deaths, safeguarding incidents, serious injuries and events that stopped the service. However, notifications had not been submitted to inform CQC of Deprivation of Liberty Safeguards (DoLS) authorisations as required by regulation. This meant that we were not able to check that people's human rights had been protected.

Whilst improvements had been made, further improvements were required. This meant that the provider was not meeting legal requirements.

The Willows

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 was meeting the breaches of regulation identified at the comprehensive inspection on 26 January 2016.

We undertook a focused inspection of The Willows on 29 June 2016. We inspected the service against two of the five questions we ask about services: Is the service Safe? and Is the service Well-led? This is because the service was not meeting legal requirements in relation to those questions when we carried out the comprehensive inspection in January 2016.

The inspection was unannounced and the inspection team consisted of one adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that have happened in the service. The registered provider was not asked to submit a provider information return (PIR) before this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with the general manager, the senior care worker on duty and a care worker, and we chatted to people who lived at the home. We looked around communal areas of the home, bathrooms, toilets and bedrooms (with people's permission). We also spent time looking at records, which included maintenance certificates, health and safety audits and the records of accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection of The Willows on 26 January 2016 we found that the premises were not being maintained in a safe way. One person had a chain across their door and we were concerned that this created a trip hazard for other people who lived at the home. An area of flooring had been temporarily repaired and this also created a trip hazard. A relative told us that the headboard on their family member's bed was loose and we saw that this was the case.

This was a beach of Regulation 12 (2) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the action plan submitted in response to the inspection of January 2016, the registered manager told us that there was an environmental audit that was completed monthly. They said that this had been made more robust to ensure that beds / headboards and flooring were included in these audits. In addition to this, staff had been reminded of their responsibility to report any faulty, damaged or broken equipment to the registered manager promptly. They told us they would achieve compliance by 7 March 2016.

At our focused inspection on 29 June 2016 we saw that the person whose headboard was damaged had been provided with a new bed. One person had a chain across their bedroom door; this was to prevent other people who lived at the home from entering their bedroom and they were happy with this arrangement. However, we were concerned that there was a risk that other people could fall over this chain. On 29 June 2016 we saw that the chain had been replaced with a gate. This was easy to open in the event of an emergency but provided a safe way of deterring people from entering the person's bedroom. This reduced the risk of an accident occurring.

We checked the flooring in the corridor close to the toilets on the first floor; this had previously been repaired but caused a trip hazard. On the day of this inspection we saw that new flooring had been fitted to make this area safe. We did not see any other areas of flooring that created a trip hazard. We saw these changes resulted in the registered provider meeting the breaches of Regulations in respect of the safety of the premises.

We checked maintenance certificates and found that the passenger lift, bath hoists and mobility hoists and slings had been serviced and that there were current service certificates in place for the electrical installation, gas safety, the fire alarm system and emergency lighting.

Spot checks had been introduced by the registered manager. These checked the cleanliness of bedrooms including wash basins, commodes, toilets, waste bins, beds and bed linen, floors and curtains. The checklist recorded 'pass' or 'fail'. Any areas that failed included a record of the action taken to rectify the shortfall. Weekly room checks included checks on profiling beds and pressure care mattresses; there was a list of the different types of mattresses provided for each person. Monthly room checks monitored room temperatures, water temperatures, window opening restrictors and emergency call bells. We saw that the check on emergency call bells included the registered manager activating a sample of bells to monitor how

long staff took to respond. Wheelchairs were also checked for safety on a regular basis, and accidents and incidents were audited each month.

In-house maintenance was carried out by the organisation's handyperson. This included a weekly test of the fire alarm system and door closers, and monthly tests of emergency lighting. The most recent fire drill had been held on 18 June 2016. There was a fire risk assessment in place that was dated 23 October 2015 with a review date of October 2016.

We saw these changes resulted in the registered provider meeting the breach of Regulation in respect of the safety of the premises.

Prior to this inspection we had received information of concern about the temperature in some bedrooms. We were told that five bedrooms were too hot and were making people accommodated in those rooms uncomfortable. We saw a document that recorded on 6 June 2016 the radiators in five bedrooms were 'running hot' and the rooms were warm. These were adjusted by a plumber but this had not alleviated the problem. A further note showed that the plumber had suggested that an electrician be contacted to put a central thermostat on the boiler so that the output could be regulated. Records showed that the electrician fitted a thermostat on 23 June 2016. During the inspection we checked these five bedrooms and found that the temperature was not too warm.

Requires Improvement

Is the service well-led?

Our findings

At our comprehensive inspection of The Willows on 26 January 2016 we found that the registered manager had not been submitting notifications to the Care Quality Commission (CQC) as required by regulation. This meant that we had not been able to check that appropriate action had been taken by the registered manager and staff following safeguarding incidents or serious injuries involving people who lived at the home.

This was a breach of Regulation 18 (Registration Regulations 2009) Notifications of other incidents.

An action plans was submitted by the registered provider in response to the inspection of January 2016. This stated there was a folder available in the registered manager's office that had copies of all sample notifications and guidance on how to use them. The form for documenting incidents within the home had been amended to include a series of questions to act as a reminder regarding who needed to be notified following incidents at the home. They told us they would achieve compliance by 7 March 2016.

On the day of the inspection we checked this folder and saw that the information recorded by the registered manager following each incident or accident was thorough. It contained a checklist that reminded staff to consider who needed to be informed of each event, such as CQC, the safeguarding adult's team and / or the area manager. When an allegation or incident of abuse had occurred, an individual safeguarding consideration log had been used to help the registered manager or other staff decide whether a safeguarding alert needed to be submitted to the local authority. There were blank 'significant event and incident record' forms ready for use.

There was a list of all incidents that had occurred at the home, including complaints, medication issues, utility failures, deaths and one incidence of unexplained bruising. Each incident had a corresponding 'significant event and incident record' form that had been completed. We saw that these incident logs had been completed appropriately and that safeguarding alerts had been submitted to the local authority and notifications had been submitted to CQC when required. We noted that this information included details of any contact with health care professionals and relatives. When the incident had been a fall, an observation chart had been added to the records to monitor the person's progress. On occasions, statements had been taken from staff to provide an explanation of events.

Since the inspection in January 2016 the registered manager had submitted notifications in respect of the following incidents; one unexpected death, four expected deaths, one safeguarding incident, three serious injuries and one event that stopped the service. The notifications had been submitted to the Commission as required, and a copy had also been emailed directly to the inspector for the service.

However, the registered manager had not been aware that they were required to submit a notification to CQC when Deprivation of Liberty Safeguards (DoLS) applications had been authorised by the local authority. We saw that there were appropriate records in respect of these DoLS applications and authorisations, including details of when the authorisations needed to be renewed. Following the day of the inspection, the

registered manager sent us a list of the people living at the home who had a DoLS authorisation in place. Seven people had authorisations in place; one authorisation had been granted before the registered manager was in post and she had submitted an application for renewal. The registered manager had submitted a further seven applications to the local authority and was awaiting a decision about authorisation. We saw there was a notice in the registered manager's office that stated, 'Staff to ensure when the GP comes to certify a death that the GP is made aware that the resident has a DoLS in place if this is so'. This showed that the registered manager had an understanding of the policies and procedures in respect of DoLS and had shared this information with staff.

Although there had been improvements in the submission of some notifications, the registered provider was not fully meeting legal requirements. This was a continued breach of Regulation 18 (Registration Regulations 2009) Notifications of other incidents. We are addressing this breach with the registered provider.