Willow Home Care Ltd

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Inspection report

Unit 3
Walkmill Business Park
Market Drayton
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Tel: 01630478913

Date of inspection visit:
16 June 2021
21 June 2021

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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

About the service
Willow Home Care Ltd is a domiciliary care service providing personal care and support to people in their own homes. They were providing a service to 57 people at the time of inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
People were not always being provided safe care and treatment. Risks to people's safety and health were not always assessed or mitigated which exposed them to risk of harm. Medicines were not always given as prescribed and the guidance for staff was not effective, leaving people at risk of their health deteriorating.

We found significant concerns about the management of the service. Their systems were either not in place or not effective to assess, monitor, and improve the quality and safety of the service. Their systems had failed to ensure risks were properly assessed, documented and mitigated. The provider had failed to ensure care staff had guidance in place to provide safe care and treatment to people.

People did not have personalised Covid-19 risk assessment but were supported by staff who understood how to reduce risks associated with Infection Prevention and Control. People said staff wore and disposed of Personal Protective Equipment (PPE) safely. We have made a recommendation about managing Covid-19 risks. People felt safe with the care they received and knew how to raise concerns with the service. Staff understood how to raise concerns regarding people's safety.

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 20 November 2019).

Why we inspected
The inspection was prompted by risk information we held about the service, As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating of the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified breaches in relation to people's safe care and treatment, managing risks to people's safety; governance and oversight of the service at this inspection.

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 continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. We will work alongside the provider and local authority to monitor progress. 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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Willow Home Care Ltd

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
This inspection was carried out by one inspector.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service less than 24 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 16 June 2021 and ended on 23 June 2021. We visited the office location on 16 June 2021 and 21 June 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Health Watch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 used all this information to plan our inspection.

During the inspection
We spoke with three people and two relatives about their experience of care provided. We spoke with five members of staff, including the registered manager who was also the nominated individual, the director of the service and three healthcare assistants. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included five people's care records and multiple medicines records. We looked at three staff files in relation to recruitment. We also looked at a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to ensure immediate actions to mitigate specific risks were completed.

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.

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

- People's risks were not always fully assessed or documented to provide guidance for care staff to support people safely. For example, two people required catheter care to manage their continence needs. There were no specific continence risk assessments or care plans in place for staff to refer to, which increased the risk of harm occurring.
- People's mobility and manual handling needs, and risks were not accurately documented to provide information and guidance for care staff to support people safely. For example, two people required a hoist to support them in manoeuvring around their homes. There was no risk assessments or care plans in place to guide care staff in supporting people in the use of hoist equipment which increased the risk of harm occurring.
- People's skin integrity risks and needs were not always fully assessed or had care plans in place for staff to monitor the condition of people's skin. For example, four people were at risk of skin deterioration due to continence or immobility needs. There was no specific risk assessments or care plans in place to fully identify people's skin health or to provide guidance to care staff on how to support and monitor people's skin integrity.
- People with needs and risks associated with diabetes did not have risk assessments or care plans in place to support them with these needs. For example, two people had type 2 diabetes however there was no information in their care records to guide care staff in how to monitor and support people with their diabetes or how to escalate concerns to relevant health professionals. Care staff had not received training for diabetes care. This increased the risk of harm occurring.
- A person with swallowing difficulties (Dysphagia) did not have accurate, consistent or complete information about their needs in order to manage and mitigate their swallowing risks. The person had been assessed by the Speech and Language Therapy (SALT) team who recommended a modified diet and for their drinks to be thickened to specific guidelines. This information was not incorporated into a nutrition and hydration risk assessment or care plan to guide care staff in supporting the person safely. There was a choking risk assessment in place, however this was inaccurate as it stated the person could "chew a normal" diet and did not have thickener in their drinks. These errors and lack of guidance for care staff increased the risk of harm occurring.
- People with neurological disorders did not have risk assessments or care plans in place. For example, one person lived with Parkinson's disease and another person lived with epilepsy. Care staff did not have information to guide them in understanding the associated and individual risks of these conditions or how

to support and mitigate the risks. Care staff had not received Parkinson's disease or epilepsy training. This increased the risk of harm occurring.
● People's medicine administration records (MAR) and risk assessments were not always complete, recorded accurately, nor medicines administered safely. For example, two people were prescribed medicine to manage pain. We found both people were administered their pain medicine before the minimum time allowance for a next dose on multiple occasions. This increased the risk of significant harm occurring.

We found the provider had failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance was not in place for staff to follow to keep people safe and people were left at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to our feedback following inspection by submitting an action plan to us and confirmed medical advice had been sought for the people who had been administered medicines before their next dose was allowed. We found no evidence people had been harmed due to the failings identified above, however the risk of harm was present due to these failings.

Preventing and controlling infection
● We were somewhat assured the provider had effective infection control procedures in place. However, people had generic Covid-19 risk assessments in place which were not detailed or personalised to their individual health needs.

We recommend the provider refers to current guidance on the assessment and management of associated Covid-19 risks and take action update their practice.

● People gave us positive feedback regarding the use and disposal of personal protective equipment (PPE) by care staff. One person told us "They (carers) know what they are doing; they're always wearing masks, gloves and aprons and washing their hands." Care staff we spoke to understood their responsibilities in relation to infection control and hygiene and had been trained in this area.
● The provider had infection prevention and control policies in place.

Staffing and recruitment
● People gave mixed reviews regarding the consistency of their care call times by carers. One person told us "Sometimes they (carers) are pushed for time or they have to swap carers around, but they inform me beforehand if there are any problems." Another person told us "The (carers) arrive on time and they are pretty consistent with it." However, we found there were inconsistences between people's call times in order to provide safe and effective care. For example, one person required four care calls per day, however they were regularly visited by carers within a two hour gap between care calls. This was not safe or effective as the person required time sensitive medicines.
● Staff were recruited safely. Employment checks were completed including employment history, references and proof of identity was checked. Disclosure and Baring Service (DBS) checks had been completed which help to prevent unsuitable staff from working with people who are vulnerable. The Disclosure and Barring Service helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
● People felt safe with the care and support they were provided and knew how to raise concerns. One person told us "I feel perfectly safe, I don't have to tell them (carers) what to do, they know exactly what they are doing and if I need to explain anything, they do listen."

● Staff had completed safeguarding training. Staff we spoke with understood their safeguarding responsibilities and knew how to raise concerns.
● The provider had appropriate policies and systems in place to raise safeguarding concerns.

Requires Improvement

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 Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The providers governance and quality assurance processes failed to provide oversight in the quality and completeness of people's care assessments, risk assessments and care plans. Care plans lacked guidance for staff to follow in order to provide safe care and treatment. Risks were particularly increased for people with complex care needs, including manual handling, hoist transfers, diabetes management, epilepsy, swallowing difficulties, continence care and pressure care. Auditing systems and processes were not effective in identifying these failings nor were audits identifying the lack of consistency throughout care records. This increased the risk of harm occurring.
- The provider had not ensured people's medicine records were complete, recorded accurately or medicines administered safely. Risk assessments did not always detail people's current prescribed medicines.
- The provider had failed to ensure the electronic MAR systems they were using was effective. The system failed to alert carers when time sensitive medicines should not be administered because enough time had not passed since people's last dose. Medicine administration outcome statements did not provide assurances as to whether people had been administered medicines or otherwise. This increased the risk of errors and harm occurring.

We found care and governance systems and processes had not been established and operated effectively to keep people safe. This placed people at risk of significant harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded to the findings by submitting an action plan to us. We found no evidence people had been harmed due to the failings identified above, however the risk of harm was present due to these failings.

- The provider had processes in place to monitor staff performance in providing care to people. Staff told us they were receiving regular spot checks and supervision to evaluate their performance and we found evidence this was being documented. However, actions identified during spot checks were not always followed through by the management team. For example, a staff member's spot check documentation

stated they required a refresher for medicines training. There was no rationale provided as to why this was required, and this was not discussed during the staff member's following supervision session. At the time of inspection, the staff member had not completed a refresh of this training.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider had been completing team meetings and sent care staff important updates and information by email. However, the provider explained team meetings were difficult to organise due to Covid-19 government guidance and were reliant on video conferencing technology which was not always effective. One staff member told us "We have felt disconnected from the management and office team since the pandemic, however if we need advice or support, they respond quickly."

● People were encouraged to express their views about the service. One person told us "I fill out a questionnaire about once a year, if I need any changes this gets arranged." A relative told us "I speak to the manager regularly; they are always very helpful with anything we need."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider understood their legal requirements. We found there were systems in place to record, investigate and feedback on any incidents, accidents or complaints. However, there were no recent accidents, incidents or complaints on file at the time of inspection. Due to the failings described above, we could not be assured the systems in place were effective in their purpose.

● The provider responded promptly to the concerns identified regarding the medicine administration errors. People's GP's were contacted to seek medical advice and full duty of candour processes were completed.

Working in partnership with others

● People were supported to access external care and support from health and social care professionals. One person told us "I had severe pain in my stomach for a few days which the carers noticed, they contacted my doctor for me and I'm much better now." A staff member told us a person had a fall but was not injured, however referred to the person's GP for extra support around falls risks.

● The provider had systems and records in place where they had been working with the local authority to investigate concerns and queries regarding people's care and treatment.

● The provider was working with a local college to support young people into a health and social care career.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance was not in place for staff to follow to keep people safe and people were left at risk of harm.

The enforcement action we took:

We issued the provider a warning notice specifying the date where they are required to be compliant with the regulation. If they fail to be compliant with the relevant requirement within the given timescale, we may take further action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people's needs and risks were comprehensively assessed and recorded accurately. Guidance was not in place for staff to follow to keep people safe and people were left at risk of harm.

The enforcement action we took:

We issued the provider a warning notice specifying the date where they are required to be compliant with the regulation. If they fail to be compliant with the relevant requirement within the given timescale, we may take further action.