Care Quality Commission

Exalon Care Limited

The Willows

Inspection report

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Date of inspection visit: 16 December 2014
Date of publication: 18/02/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The Willows provides accommodation and personal care for up to ten people with a learning disability or mental health issues. At the time of our visit there were seven people living at the home. The Willows is situated on the outskirts of Warminster in Wiltshire. Bedrooms are on the ground and first floor. There are two shared bathrooms and some bedrooms have their own washing facilities.

During our last inspection on 09 April 2014 we found the provider to be in breach of Regulation 12 Cleanliness and infection control. This was because measures had not been taken to ensure adequate standards of cleanliness and hygiene in relation to the bathrooms. The provider wrote to us with an action plan of improvements that would be made. During this inspection we found the provider had made the required improvements to the cleanliness of the bathrooms, however we found further concerns around the standard of cleanliness within other areas of the home.

The service did not have a registered manager in place. 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.

Summary of findings

At the time of our inspection, the home was being supported by an interim manager who was a registered manager within another of Exalon Care limited group homes. The provider had notified us that a new manager had been recruited and would be starting at employment at The Willows during the first week of January 2015.

People who live at The Willows told us they either felt safe all of the time or most of the time. There were sufficient number of staff to meet peoples needs. Staff were confident in their knowledge of recognising and reporting safeguarding concerns

The standard of cleanliness within the home was not consistent. Some areas such as window sills, skirting boards and doors were not clean. The floor of a linen cupboard was dusty. Not all staff followed safe food handling practices. The provider's system for infection prevention and control was not in accordance with the Code of Practice for health and adult social care. The Code of Practice applies to registered providers of healthcare and adult social care and sets out the standards of infection prevention and control required under the Health and Social Care Act 2008.

We found errors in the recording of the administration, storage and disposal of medicines. The lack of an accurate record of medicines held in the home increased the risk that medicines may be misused.

Some areas of the home were not safe. There were electrical fuse boxes in two of the bedrooms which had not been locked. At the top of a flight of stairs, two adjacent doors opened up towards each other. There was a risk of injury either through trapped fingers or from losing balance and falling down the stairs. The provider had not ensured people were protected from unsafe or unsuitable premises.

Staff did not fully understand their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty (DoLS) which may impact on their ability to protect people's rights.

People told us they enjoyed the food and had enough to eat and drink. People had full access to the kitchen and could prepare their own meal or snack if they wished. Staff treated people with respect and protected people's privacy and dignity. Staff supported people to make their own decisions and were aware of people's likes and dislikes and preferences for their care routines

Each person had a care plan which included information on maintaining people's health, their daily routines and personal care. Health and social care professionals were involved in people's care.

There was a lack of planning and availability of meaningful activities which people could take part in. People's wellbeing was not promoted due to a lack of activities to meet their social, mental and emotional needs.

Staff received support and training to do their job and told us that the management team were approachable. There were systems in place to ensure that staff received support through supervision and an annual appraisal to review their on-going development. Supervision and appraisals are processes which offer support, assurance and develop the knowledge, skills and values of an individual, group or team. The purpose is to help staff to improve the quality of the work they do, to achieve agreed objectives and outcomes.

People told us they knew how to make a complaint if they wished to. People and staff felt they could approach the manager if they were not happy with the care or service provided.

The quality assurance process in place for the medicine and infection control audits was not effective. There was a lack of detailed information to clearly identify, assess and manage the risks relating to the health, welfare and safety of people who use the service.

There were several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. The standard of cleanliness within The Willows was not consistent. Some doors, windows sills and skirting boards were not clean.

People were supported to take their medicines; however there were errors in the recording of the administration, storage and disposal of medicines.

People we spoke with either told us they felt safe living at The Willows or felt safe most of the time. Staff were knowledgeable about reporting concerns if they suspected abuse.

Is the service effective?

Requires Improvement

The service was not effective. Staff did not fully understand their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty (DoLS) which may impact on their ability to protect people's rights.

Staff received support and training to do their job and told us that the management team were approachable.

People told us they enjoyed the food and had enough to eat and drink. People had full access to the kitchen and could prepare their own meal or snack if they wished.

Is the service caring?

Good

The service was caring. People told us that the staff were kind and caring and they liked living at The Willows.

Staff treated people with respect and called people by their preferred name.

People told us they were involved in the planning of their care and staff explained things if they were not sure about something.

Is the service responsive?

Requires Improvement

The service was not responsive. People were not engaged in any meaningful activity such as work, study, sports or taking part in social groups. The activities identified in each person's timetable were not routinely being followed.

Each person had a care plan which included information on maintaining people's health, their daily routines and personal care.

People told us they knew how to complain if they had any concerns.

Summary of findings

Is the service well-led?

The service was not well led. The quality assurance process in place was not robust enough for the medicine and infection control audits to be effective. There was a lack of detailed information to clearly identify, assess and manage the risks relating to the health, welfare and safety of people who use the service.

The provider had a development plan in place for the refurbishment of the home with expected completion dates. There were emergency plans in place for the loss of utilities and for staff shortages through one of the other Exalon Care group homes.

Requires Improvement

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 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 16 December 2014 and was unannounced. This inspection was carried out by two inspectors.

Before the visit we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This enabled us to ensure we were addressing potential areas of concern and best practise.

We spoke with three of the seven people living at The Willows. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to assist us to understand the experiences of the people who could not talk with us. We spent time observing people in the communal areas.

During our inspection we spoke with the interim manager, a deputy manager, a team leader, the care co-ordinator and a support worker. Following our visit, we contacted people who visit the home to find out what they thought about this service. We contacted three health and social care professionals.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking to people, looking at documents and records that related to people's support and care and the management of the service. We reviewed the care records of three people, looked at staff training documents, staff handover documents, cleaning schedules, medicine administration records, the refurbishment programme for The Willows, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

Requires Improvement

Is the service safe?

Our findings

During our last inspection on 09 April 2014 we found the provider to be in breach of Regulation 12 Cleanliness and infection control. This was because measures had not been taken to ensure adequate standards of cleanliness and hygiene in relation to the bathrooms. The provider wrote to us with an action plan of improvements that would be made. During this inspection we found the provider had made the required improvements to the bathrooms. However, the standard of cleanliness within the home was inconsistent. Some items were not on the cleaning schedules and were not routinely being cleaned or were not clean.

On the first floor of the property was a storage cupboard which held clean bed linen and towels. On the floor of the cupboard were discarded items which were dusty and dirty. This included a stool, packaging and a pair of stereo speakers. The task of cleaning this cupboard was not on any of the cleaning schedules. Throughout the home we saw doors which had grime and fingerprints around the door handle area. The cleaning schedule stated that the door handles were to be cleaned and we saw they had been, however there was no record of cleaning the area around the door handles which were dirty. This increased the risk of cross infection.

The window sill and skirting boards in the communal lounge were not clean and not all tasks were on the cleaning schedule. The window sills, skirting boards and paintwork were clean in some bedrooms but not in others. One bedroom had dead flies in the enclosed ceiling light.

Not all of the bedrooms were dust or grime free due to the level of clutter in the rooms. We spoke with the deputy manager about this. They explained they were working with people on an informal basis to de-clutter their room to enable a deep clean. However, there were no risk assessments or action plans in place to address this in a timely manner. The bedrooms had not been deep cleaned and there was no timetable of how often deep cleaning would take place.

The kitchen was clean throughout. Staff used appropriate protective gloves and aprons when preparing food. There was a notice on display which gave guidance on which chopping boards to use for food preparation and we saw this had been followed. However, not all staff were adhering to safe food hygiene practices as documented in the provider's infection control policy. The fridge contained food which had been opened and some items had been labelled with the date of opening. We also saw other items such as packets of ham which had been opened but were not labelled. This put people at risk of developing food borne illness due to eating out of date products.

In the kitchen, a separate sink was available for hand washing and staff had access to supplies of soap and paper towels. The type of waste disposal bin available meant that staff had to lift the lid of the bin to dispose of paper towels. This could potentially cause bacteria to spread and cause cross contamination with food products.

The provider had a refurbishment programme in place for the home. At the time of our visit, the communal areas of the home were being redecorated and the bathrooms had recently been refurbished. We found several safety hazards which had not previously been identified by the provider. For example, at the top of the stairs was a fire door which opened into the first floor hallway. Directly opposite was a bathroom where the door also opened into the hallway. Unknowingly, we opened the fire door to get to the first floor at the same time as a member of staff came out of the bathroom. On this occasion we were able to avoid the doors meeting. There were no safety or warning signs displayed and a risk assessment was not in place to assess and minimise the potential risks to people.

In one of the bedrooms, the tiling at the front of the vanity unit was chipped and the edging strip had come away, exposing rough contiboard and a jagged edge which could cause injury. Two of the bedrooms which were occupied contained electrical fuse boxes which were not locked or secure. There were live wires inside the box coming from the meter base. This may cause people at risk of injury or harm.

The provider had not ensured people were protected from unsafe or unsuitable premises. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Medicines held by the home were securely stored and people were supported to take the medicines they had been prescribed. We saw a medicines administration record (MAR) had been completed which gave details of the medicines people had been supported to take. Although people were supported to take their medicine, the records

Requires Improvement

Is the service safe?

of medicines held in the home were not always accurate. For example, on one MAR sheet there was no record of the number of tablets carried forward from the previous sheet, therefore the current record of stock held was not accurate. Five people kept PRN medicine in their room (PRN is medicine taken as and when required for example paracetamol) however; there was no record of the medicine or the number in stock. On the afternoon of our visit we saw from the medicine records that a member of staff had signed to say they had administered a medicine which should have been taken at 6.30pm that evening. We asked the deputy manager to investigate this.

The signing sheet for staff authorised to administered medicines had not been dated. This meant that the manager could not be assured that it was the most up to date list and contained only those staff who were authorised to administer medicines. Ibuprofen tablets which were issued on the 26 May 2014 were not detailed on the MAR sheet and had not been disposed of as required. The pharmacy who collected stocks to be disposed of had not routinely signed the sheets to confirm they had removed the medicines.

The lack of an accurate record of medicines held in the home increased the risk that medicines may be misused. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they either felt safe living at The Willows all of the time or safe most of the time. Some people did not like it when there was a disagreement between people. Staff had received training in safeguarding to protect people from abuse. Training records confirmed that staff had received appropriate training. Staff were able to describe what may constitute as abuse and the signs to look out for.

There was a safeguarding and whistleblowing policy and procedures in place which provided guidance on the agencies to report concerns to. Whistleblowing is when a worker reports suspected wrongdoing at work in relation to the care and welfare of people they care for. Officially this is called 'making a disclosure in the public interest'. A senior member of staff told us “I would pass on any concerns to the manager and make a referral to the safeguarding team if needed”. Another care worker told us “I would report concerns to my team leader and would be prepared to go higher”.

Documents evidenced that the management team reported concerns to the local authority safeguarding team and notifications were made to the Care Quality Commission as required.

There were adequate staffing levels in place to support people . We saw that staff were visible and available to people. The deputy manager told us that although they had vacancies for people at this time, the staffing allocation had remained the same. As new people moved into the home they would review the staffing numbers based upon the needs of new residents.

We reviewed the incidents and accidents which had occurred within the home. Since the summer of 2014, there had been a decrease in the number of incidents occurring between people who use the service. Risk assessments had been reviewed and action plans put into place which described how staff should reduce or minimise risks. This also included specific instructions on intervention. This meant that people were further protected from the risk of harm through incidents and accidents.

Requires Improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards is part of the Act. The DoL's provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Staff told us they did not use any form of restraint on people and would use distraction techniques or remove themselves from the area to diffuse a situation. Staff were aware of promoting people's human rights and that decisions should be taken in the best interest of the person. The deputy manager told us all staff had recently received a brief refresher of the MCA and further, more in-depth training had been booked.

The staff did not have a clear understanding of how the MCA enabled others to make decisions on behalf of those who lacked the mental capacity to do so safely for themselves. Or, what may constitute as a deprivation of liberty and the processes involved in determining the person's best interests.

We looked at three care plans which each documented if the person had capacity. However, there were no formal mental capacity assessments in place. There was a lack of detail about what decisions people could safely make, what decisions they may require support with and those areas of their daily living which may pose a risk. We raised this with the deputy manager who stated that they were in the process of liaising with health and social care professionals for assessments to be completed.

A lack of formal capacity assessments, together with a lack of staff understanding of the MCA and DoL's, could result in people being inadvertently deprived of their liberty and their human rights. This was a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

New staff undertook a probationary period in which they completed an induction linked to the Skills for Care, Common Induction Standards (CIS). CIS are the standards people working in adult social care need to meet before they can safely work unsupervised. The induction included looking at care plans, completing the mandatory training, familiarising themselves with the service policies and procedures and shadowing more experienced staff members.

Staff told us they received regular supervision with either the team leader or deputy manager. During supervision, training and skill development was discussed. Staff said they felt supported and feedback during these sessions was constructive.

Each member of staff had been booked in for an annual appraisal during February and March 2015 with the new manager. Supervision and appraisals are processes which offer support, assurance and develop the knowledge, skills and values of an individual, group or team. The purpose is to help staff to improve the quality of the work they do, to achieve agreed objectives and outcomes.

Staff said they were happy with the training offered by the provider and felt they had received sufficient training for their role. The training matrix documented that staff had completed the mandatory training required or had been booked for a refresher course. Mandatory training was carried out for; safeguarding vulnerable adults, infection control, manual handling, food hygiene, strategies for managing behaviour, first aid, health and safety and fire training.

Some staff had completed training which was specific to people's needs such as, epilepsy awareness, autism awareness and medicines. Other training such as sign language had been planned for 2015. All staff had completed Multi Agency Public Protection Arrangement training (MAPPA) to ensure they were aware of their role in supporting people who may be referred or supported through this agency. The MAPPA agency supports people with mental health and other needs to help them settle into the community whilst protecting the public.

Requires Improvement

Is the service effective?

People told us they enjoyed the food and had enough to eat and drink. People had full access to the kitchen and could prepare their own meal or snack if they wished. Staff had more recently taken on the role of preparing lunch to encourage people to sit together in the dining room. One person showed us the cupboard in the kitchen and said "snacks are in these cupboards, things like crisps, chocolate and biscuits, the staff get the shopping every week so we can tell them if we want something different". We saw that fresh fruit was readily available in the kitchen.

In the kitchen was a list of food dislikes and dietary requirements. One person was a vegetarian and they told us they were happy with the selection and quality of the food. We looked at a menu planner which listed each day's menu along with the vegetarian option. The evening meal which was prepared that day was curry, although this was not the meal which was given on the menu planner. A member of staff said they would ask people if they still wanted what was on the menu and would change it if they did not. Staff told us they asked people what they would like to eat and the menus were discussed during the house meetings.

Some people could not remember if they were asked to put forward ideas for the menus. There was a lack of information which evidenced that people had been consulted about their menu preferences. The interim manager explained an advocacy service would be visiting the home regularly to support people to speak up about their wishes. They hoped this would empower people to put forward ideas and be more involved with meal planning.

The care records [electronic and paper] evidenced that health and social care professionals were involved and provided support and guidance to people and staff who delivered their care. Referrals had been made to health specialists such as a dietician, hospital consultants, dental and optical services. The interim manager explained they had made referrals to the local community health team for people's health care action plans to be updated.

Good

Is the service caring?

Our findings

People told us they liked living at The Willows and most of the time everyone [people] 'got on'. One person said "I like living here, the staff treat me well". Another person told us "staff are kind and chat to me". One member of staff said "most of us have worked here for many years, it's a really good place to work, and I enjoy what I do".

All of the staff interactions with people were friendly, respectful and caring. We saw that people and staff had developed positive relationships with each other. There was often light hearted banter between staff and people with an unspoken understanding of the boundaries between friendship and professionalism. We observed that staff respected people's privacy by knocking on their bedroom door and waiting until being invited in. When staff entered the communal rooms they acknowledged people and called them by their preferred name.

The accommodation in The Willows was roomy and we saw that people wandered around freely as they wished. People did their laundry, read in the lounge or made their lunch. One person told us "I can go wherever I want, I have the code to the front door, I usually go into town". Another person told us "they [staff] know what I like and understand me". All of the people we spoke with said staff encouraged them to be independent in their daily living, but were there if they needed support.

Upon speaking with care staff, we found they were knowledgeable about the people in their care. Staff were mindful of people's emotional wellbeing and we saw if individual people were agitated or distressed, staff used effective techniques to reassure and calm them. Staff told us that as some people could not verbalise their wishes clearly they looked for other 'cues' such as facial expressions and sounds. We observed that staff took time to listen to people and supported them to make their own choices.

People told us they were involved in the planning of their care and staff explained things if they were not sure about something. The interim manager told us they had recently employed the services of an advocacy group. In January 2015, two members of the advocacy service would visit several times a month to get to know people. From this, they hoped to empower people to become more involved in making decisions about their care and support and the running of the home.

Requires Improvement

Is the service responsive?

Our findings

People told us their relatives visited at times which suited them and they regularly visited their family home. People told us what their interests and hobbies were, such as bike riding, dancing, going shopping, music, playing the drums and going to the local park. A games room was available for people to use. There was a snooker table, board games, puzzles and other activities for people to take part in if they wished. People told us they sometimes went out for a meal and some people went to the local pub each week. Staff told us they engaged with people either through supporting them with daily tasks, chatting, watching television together, and going out for drives or into the local town for shopping.

The care records contained information about the person's family background, what was important to them and how they liked to spend their time. Each person had a daily activity timetable in place which identified what they had chosen to do that week. One person told us "I don't get bored, there is usually something I can do, I can always go into town". Although there were activity timetables in place for each person, we found people were not taking part in the activities listed. One person had swimming sessions listed on their timetable but told us they had not been swimming for a 'long time'. The deputy manager explained they were in the process of reviewing the activities people wanted to do.

During our visit we observed that although staff were visible and interacted with people, they were occupied with completing paperwork, cleaning or cooking and some people followed them as they carried out their work. Two people went out and one person was visiting their family.

There was a lack of assessed need and planning around activities. People were not engaged in meaningful activities such as work, study, sports or taking part in local social groups.

People's wellbeing was not promoted due to a lack of planning and availability of activities to meet their social, mental and emotional needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

As part of the care planning process, the interim manager told us they had started to use the tool 'Pathways to Independence'. This tool helped to create a personal development plan for people based upon the skills they needed to develop. They explained they had started the process by looking at personal hygiene, oral health and room cleaning. From records, we saw that each person had specific goals within these areas and there was guidance for staff on how to support people. The person's keyworker completed monitoring reports on their progress.

Each person had a care plan which included information on maintaining people's health, their daily routines and personal care. The care plans set out what their care needs were and how people wanted them to be met. The plans contained detailed and specific information, including information from health and social care professionals where necessary. For example, we saw that there were details, plans and risk assessments about the support people needed when they became distressed and challenging towards staff.

People told us they would complain to staff if they needed to. We saw there was a complaint's policy and procedure in place and that the complaints raised during 2014 had been responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection a registered manager was not in place. The provider had recruited to this post and the new manager was starting in January 2015. In the interim, the home was being managed by a deputy manager and a registered manager from another of the Exalon Care group homes.

The medicines and infection control audit tools were not effective because they were not sufficiently detailed to ensure a full and robust audit. The form did not list what items were to be audited each week in relation to all areas of the administration, storage and disposal of medicines. There was no standard recording of the outcome of the audit and what action needed to be taken. Information was not carried forward from the previous audit to ensure that action had been taken. Likewise, for infection control there was no audit form in place which assessed against all potential areas of infection, such as food hygiene, disposal of waste and other products, standards of cleanliness and hygiene within the premises, provision of personal protective equipment, staff practice and training.

The systems in place were not robust enough to clearly identify, assess and manage the risks relating to the health, welfare and safety of people who use the service. This was a breach of Regulation 10 (1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The interim and deputy manager felt the quality of care and support offered by the home had improved and people were experiencing better outcomes. This was something they would continue to work towards.

The management team demonstrated a good understanding of their priorities and developments they were planning. The deputy manager told us they were in the process of developing a more robust auditing system. They now monitored information from incidents and accidents to highlight individual and collective risks to people. This information helped them to put appropriate measures in place to prevent and minimise future risks.

The staff training matrix had been updated which identified people who required refresher training and a programme was now in place to deliver this training. Staff supervision was being monitored to ensure staff received this and annual appraisal dates had been set for February and March 2015. When new people moved into the home or people needs changed, staffing levels were reviewed to ensure there was sufficient staff to meet people's needs.

Staff had clearly defined roles and understood their responsibilities in ensuring the service met people's needs. Staff told us they felt supported and valued and the management team were approachable. One member of staff said "the deputy will text us at the end of a shift just to say thanks". Most staff were able to say what they thought the vision of the service was. One example given was "to give people a normal life as possible and encourage independence".

There were regular staff meetings, which were used to keep staff up to date and to reinforce the values of the service and how they expected staff to work. Staff also reported that they were encouraged to raise any difficulties with the management team. Staff told us they were getting to know the senior management team as they now visited the home every couple of months. One professional told us they had found the home to be "more transparent and open in their approach".

One of the positive outcomes of 2014 was that they had been able to develop the skills and knowledge of the current staff team and to retain the same staff, without too many changes. In addition, they had put into place a transition plan for the new manager to ensure they received the support they needed to continue improving the service.

The provider had a development plan in place for the refurbishment of the home with expected completion dates. There were emergency plans in place for the loss of utilities and for staff shortages through one of the other Exalon Care group homes. The interim manager explained they had not had the capacity during 2014 to consult with people or their families about their views of the service. As part of their work with an advocacy service, they had planned to gain people's views during 2015.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines There were errors in the recording of the administration, storage and disposal of medicines. The lack of an accurate record of medicines held in the home increased the risk that medicines may be misused.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Some areas of the physical environment of The Willows were not safe and the risk assessments carried out had not identified these as potential risks. The provider had not ensured people were protected from unsafe or unsuitable premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment A lack of formal capacity assessments, together with a lack of staff understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) could result in people being inadvertently deprived of their liberty and their human rights.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Action we have told the provider to take

There was a lack of planning and availability of meaningful activities which people could take part in. People's wellbeing was not promoted due to a lack of activities to meet their social, mental and emotional needs.