Holt Green Residential Homes Limited

Willow Lodge

Inspection report

15-16 Moss View
Ormskirk
Lancashire
L39 4QA
Tel: 01695 579319

Date of inspection visit: 26/10/2015 & 06/11/2015
Date of publication: 15/03/2016

Ratings

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

Overall summary

This comprehensive inspection was unannounced, which meant the provider did not know we were coming. It was conducted over two days on 26 October 2015 and 06 November 2015.

Willow Lodge Nursing Home is located in a residential area of Ormskirk, close to the town centre and all local amenities. The home provides both single and shared facilities on two floors served by a passenger lift and stairs. There are spacious communal areas available including lounges, dining areas and two conservatories. There is parking to the front of the property and a garden area to the rear of the home. Willow Lodge provides nursing care for up to 22 people who live with Dementia.

The last full scheduled inspection was conducted on 06 October 2014. The service was, at that time fully compliant with all five outcome areas assessed.

On the first day of our inspection the registered manager was not available, due to annual leave. However, the inspection team was assisted by the nurse in charge of the home at that time. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

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. The registered manager was on duty on the second day of our inspection.

We found that each plan of care we saw varied in quality. Some were well written, person-centred documents, whilst others did not provide staff with clear guidance about people's needs and how these needs were to be best met.

The cleanliness of the premises could have been better. Areas of the environment were found to be dirty and unhygienic. Some areas were also in need of modernising, updating and improved maintenance. Systems and equipment within the home had been serviced in accordance with the manufacturers' recommendations, to ensure they were safe for use. However, during our tour of the home we found some areas unsafe and therefore this did not consistently protect people from harm.

We noted several hazards within the environment, including inadequate fire safety arrangements, which had not been identified and therefore created a potential area of risk for those who lived at the home. Therefore, people were not consistently safe.

We looked at medication practices adopted by the home and found failings, which meant that people were not protected against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed.

On our arrival at the home there were five care staff on duty, including the registered nurse. We observed that although the staff responded pleasantly to people's needs, it was not always in a timely manner and there were times when the communal areas of the home were void of staff members. We were told that care staff were also responsible for laundry duties during the day. Some people we spoke with felt that there were not enough staff on duty. We have made a recommendation about this.

New staff were appropriately recruited and therefore deemed fit to work with this vulnerable client group. Induction programmes for new employees were formally recorded. Supervision and appraisal meetings for staff were regular and structured. This meant the staff team were supported to gain confidence and the ability to deliver the care people needed. A wide range of training programmes were provided.

Evidence was available to show that surveys for those who lived at the home and their relatives were conducted. However, these were not on public display at the time of our inspection. We have made a recommendation about this. We saw that staff meetings took place, but meetings for those who lived at the home and their relatives had not yet been established. We have made a recommendation about this.

Consent had been obtained through best interest decision making processes before care was provided. We found that people were not consistently treated with dignity and respect. The planning of people's care varied. Some records were person centred and well written, providing staff with clear guidance about people's needs and how these were to be best met. However, some did not identify all assessed needs. Some records were not maintained in a confidential manner. We have made a recommendation about this.

Meal times were not conducive to a pleasant dining experience and the importance of respecting people's privacy and dignity when sharing a bedroom was not recorded within individual plans of care. We have made recommendations about these areas.

We found several breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for safe care and treatment, premises and equipment, dignity and respect, person-centred care and good governance.

You can see what action we told the provider to take at the back of the full version of this report. We are taking enforcement action against the service and will report on that when it is complete. We have served a warning notice in relation to none compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have not received any representations from the provider. The provider is required to become compliant by 27 March 2016.

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

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?

Inadequate 

This service was not safe.

We noted that moving and handling practices were not always conducted in a safe manner and that several hazards within the environment, including inadequate fire safety arrangements had not been identified and therefore created a potential area of risk for those who lived at the home.

Infection control protocols were not being followed and medicines were not being well managed. Areas of the premises were found to be dirty and unhygienic. Therefore, the prevention of cross infection and contamination had not been promoted.

We have recommended that the registered provider reviews the staffing levels in accordance with the assessed needs of those who live at the home, to ensure the number, experience, skill mix and deployment of staff is suitable for people's needs.

Recruitment practices were thorough enough to help ensure only suitable staff were appointed to work with this vulnerable client group.

Is the service effective?

Requires improvement 

This service was not always effective.

New employees had completed a formal induction programme when they started to work at the home. There were structured mechanisms in place for staff support, such as formal supervision and appraisal sessions.

Mandatory learning programmes were provided for the staff team and additional modules were available, in relation to the specific needs of those who lived at the home. The training programme provided a wide range of learning modules.

Freedom of movement within the home was evident and we did not observe this being restricted. However, some areas of Willow Lodge were in need of updating and modernising. The environment was not well maintained.

Consent had been obtained through best interest decision making processes before care and treatment was provided. No-one was being unlawfully deprived of their liberty.

Is the service caring?

Requires improvement 

This service was not consistently caring.

People were not consistently treated with dignity and respect. However, staff were seen to engage with people in a kind and caring manner and they were, in general well presented.

Summary of findings

People were supported to access advocacy services, should they wish to do so, or if a relative was not involved and they were unable to make some decisions for themselves. An advocate is an independent person, who will act on behalf of those needing support to make decisions.

Is the service responsive?

Requires improvement

This service was not always responsive.

An assessment of needs was conducted before a placement was arranged at the home and care plans were found to have been completed, but the standard of these varied. Some were well written, person centred documents, but others did not always reflect people's current needs. Information about how people wished to be supported and what they liked or disliked was not always recorded.

Some activities were provided, but these were not available on a daily basis. Evidence was available of activities, which had been enjoyed by those who lived at Willow Lodge.

Is the service well-led?

Requires improvement

This service was not consistently well-led.

Records showed that annual surveys were conducted for those who lived at the home and their relatives. Staff meetings had been held, but meetings for those who lived at the home and their relatives had not yet been established.

Systems for assessing, monitoring and mitigating risks were not effective, as issues found at our inspection had not been identified, so that any improvements could be implemented, in accordance with the results of a robust auditing mechanism.

Evidence was available to demonstrate the home worked in partnership with other relevant personnel, such as medical practitioners and community health professionals.

We received positive feedback about the manager of the home and her staff team.

Willow Lodge

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 legal requirements and regulations associated with the Health and Social Care Act 2008. We also looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

This inspection was carried out on 26 October 2015 and 06 November 2015. The first day was unannounced. The registered manager was given short notice of the second day of our inspection. The inspection was conducted by two Adult Social Care inspectors from the Care Quality Commission (CQC), a dementia care specialist, a pharmacy inspector and an expert by experience. An expert by experience is a person who has experience of the type of service being inspected.

At the time of our inspection to this location there were 22 people who lived at Willow Lodge. Due to the mental capacity of those who lived at the home it was not possible to speak with many, although we did manage to chat with seven of them and some relatives. We also spoke with four staff members.

We toured the premises, viewing all private accommodation and communal areas. We observed people dining and we also looked at a wide range of records, including the personnel records of three staff members and the care files of nine people who lived at the home. We 'pathway tracked' the care of five of them. This enabled us to determine if people received the care and support they needed and if any risks to people's health and wellbeing were being appropriately managed. Other records we saw included a variety of policies and procedures, medication records and quality monitoring systems.

The provider completed and submitted a Provider Information Return (PIR) within the time frames requested. A PIR 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.

Prior to this inspection we looked at all the information we held about this service. We reviewed notifications of incidents that the provider had sent us since our last inspection, such as serious incidents, injuries and deaths. We spoke with local commissioners and asked five community professionals for their feedback about the services provided at Willow Lodge. We did not receive any responses.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Willow Lodge. Relatives we chatted with also felt their loved ones were safe at the home. One told us, "There's always someone there to watch him. They watch him all the time. They are very good at stopping altercations, as he can be very aggressive. I have never seen any bullying or heard raised voices."

On our arrival at Willow Lodge there was one registered nurse on duty, plus four health care assistants, a domestic and the chef. We were told that the care workers were also responsible for completing laundry duties during the day. The duty rota we saw corresponded with the number of staff on duty at the time of our inspection. However, we noted several occasions where staff were not always available to respond to people's requests in a timely manner.

One person told us there were not enough staff on duty to attend to their needs. Relatives we spoke with also felt that there were not enough staff on duty to meet the needs of those who lived at the home. Their comments included: "I think they do need more staff. They are always rushing about. Although, I can always find a carer if I need one. They are very busy but they always have a chat if they have the time" and "Sometimes they get a bit short staffed at holiday times and when people are off sick." We spoke with the registered manager about the staffing levels at the home. She advised us that these would be looked at, to ensure sufficient staffwere deployed on each shift to meet people's needs.

During our tour of the home we found some areas of the environment, which presented a potential fire risk. Therefore, we requested a visit to the home by the Lancashire Fire and Rescue Service, who attended whilst we were at Willow Lodge. The fire officers in attendance conducted a full inspection of the premises at that time and they found some areas of fire safety which required improvement. As such, the provider was issued with a notice by the fire brigade, to address the issues.

We noted some other hazards, which created unnecessary risks for those who used the service. Some poorly maintained flooring created a potential trip hazard and the unsafe management of toiletries and other items presented a risk for those who lived with dementia.

We visited two people who shared a bedroom. Their room was located through a door which needed a code to access the area. There was no call bell in this bedroom for them to summon help, should they need to do so. At 10.20am both these people were fully awake in bed in their night wear. They had not been served breakfast at the time we visited them. Their shared bedroom had four wheelchairs and a pile of wheelchair footplates stored within it, which were blocking the hand wash basin.

We found the registered provider had failed to assess and identify risks to the health and safety of people who used the service and had not done all that was reasonable possible to mitigate such risks. This was a breach of regulation 12 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw various risk assessments in people's care plans in areas such as falling and moving and handling. During the course of our visit to Willow Lodge two members of the inspection team observed one person who was in the lounge in an agitated state. Two members of staff assisted him to the conservatory, where they helped him in to a chair and then continued with other duties. Shortly afterwards this individual stood up and fell over in the lounge. One of the inspectors went to summon help. Two members of staff came quickly and used an underarm lift to help this person to his feet and then assisted him back to his chair. The registered manager subsequently told us that moving and handling equipment was not suitable to be used for this individual and that this was recorded in his plan of care. However, the person in charge at the time of our inspection was not informed of this incident and no member of staff checked the individual over for any injuries.

We found that the registered provider had not protected people's health and safety because they had not ensured that persons providing care or treatment to service users had the competence, skills and experience to do so safely. This was a breach of regulation 12(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An infection control policy was in place. However, some of the bathrooms were in need of a thorough cleaning and we saw some equipment which was visibly unclean and not fit for use. The laundry department was cluttered, in need of upgrading, modernising and a thorough clean.

Inadequate

Is the service safe?

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment because infection control practices were poor. This was in breach of regulation 12(1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we checked the medicines and medication records of six people, who lived at the home and there were concerns about the management of medicines for all of them. As there were concerns about all six people, we looked at the MAR (Medicines Administration Record) charts for 15 other service users and there were also concerns with medicines on 14 of the charts we looked at. We found that all the MAR charts we looked at had photographs and allergies recorded, where appropriate; which reduced the risk of medicines being given to someone with an allergy and which followed current guidelines.

We observed the morning medicines being given by a registered mental health nurse and this was done in a very kind and helpful way towards all those who lived at the home. However, medicines were not being safely managed, as they were not always administered, as prescribed by the medical practitioners. For example, a diabetic medication was omitted for one person on one occasion and an incorrect dose was given to them on another. A sleeping tablet was omitted for another person on one occasion, because the home did not have the medicine in stock and one dose of their antibiotic was also missed, which may have resulted in a reduced effectiveness of the antibiotic treatment.

A third individual was not given their prescribed medication to help with their memory for four consecutive days, as this drug was not available within the home. This person was also prescribed a medicine to thin their blood. However, an incorrect dose was given on one day and on another occasion, the MAR had not been signed to indicate the drug had been administered. Therefore, it was unclear whether this particular dose had been missed or whether it had been given without being signed for.

Another person who was prescribed a medicine for Parkinson's Disease was not given a dose on one occasion, as it was not available in the home and we noted that the MAR chart had many missing signatures to show this medication had been administered as prescribed.

A fifth person had been discharged from hospital with a prescription for a powder to thicken fluids, in order to help with swallowing difficulties. However, the powder was not available in the home on the day of our inspection. This meant that the person's fluid and food could not be thickened as advised by the hospital. Another person who was taking various medicines for a heart condition, an eye problem and to stabilise their mood, was not given their medicines as they were asleep at the time the medications were being distributed. Many of these medicines could have been offered once the person was awake, but there was no record of this happening and no record to show the individual's doctor had been informed about the prescribed medications being omitted.

The other 14 MAR charts we examined raised various concerns about the management of medications, which included: medicines not being signed for; tablets not being given when people were asleep; antibiotic courses not being completed or given regularly and for one person, the antibiotic course was continued for a day and half after it should have been finished. There were also two other people who were not given their medicines to help with memory as the medicine was not in the home. We checked the quantities and records of four people, who lived at the home and found that the remaining balances of their medicines did not correspond with the records we saw.

The home had implemented an electronic system for the management of medications, in order to prevent errors occurring. The electronic system also held a record of the number of medicines that should be in the home at any given time. The quantities recorded on the electronic system on the day of our inspection did not consistently match the quantities that were available within the home. Therefore, this system was not effective and did not always protect people from the mismanagement of medications.

We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not well managed. This was in breach of regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the personnel records of three members of staff. All files we looked at contained evidence that application forms had been completed by people and interviews had taken place prior to them being offered employment. Disclosure and barring (DBS) checks

Inadequate

Is the service safe?

had been conducted before people started to work at the home. This helped to ensure that potential employees did not have any criminal convictions, which would make them unfit to work with this group of people and that they had not been barred from working with vulnerable adults.

Two references had been sought before the commencement of employment. This helped to ensure new employees were of suitable character and they had the qualifications, skills and experience to support people who lived at Willow Lodge. Records showed that the home had consulted the Nursing and Midwifery Council, the professional body for the regulation of registered nurses and midwives, to ensure nurses who worked at Willow Lodge were eligible to practice and had maintained their registration.

Detailed policies were in place in relation to safeguarding adults and whistle-blowing procedures. Staff spoken with told us that they had received training in this area and were fully aware of action they needed to take, should they be concerned about the safety or welfare of someone who lived at Willow Lodge. Information about the importance of safeguarding vulnerable people was clearly displayed within the home, so that everyone accessing the service would be able to establish how to make a safeguarding referral, should the need arise.

Certificates were available to demonstrate systems and equipment had been serviced, in accordance with manufacturer's recommendations.

We observed people were free to move around the home, without any restrictions being imposed. We saw two care workers transferring one person with the use of a hoist. This manoeuvre was performed in a competent and safe manner. The members of staff ensured the service user was comfortable and relaxed throughout the procedure, which was pleasing to see.

A business continuity plan had been introduced, which provided staff with clear guidance about action they needed to take in the event of an emergency situation, where evacuation of the premises would be needed. For example, in the case of fire, flood, bomb threat or gas leak. This was supported by an easy to follow flow chart for emergency situations. Certain emergency protocols had also been developed for urgent situations, such as a heat wave, power failure or severe weather conditions.

Personal Emergency Evacuation Plans (PEEPs) had been introduced. The purpose of these is to provide guidance for any relevant party, such as the emergency services, about how each person would need to be evacuated from the building in the event of an emergency, should the need arise. For example, in the case of fire or flood.

We recommended that the registered provider reviews the staffing levels in accordance with the assessed needs of those who live at the home, to ensure the number, experience, skill mix and deployment of staff is suitable for people's needs.

Requires improvement

Is the service effective?

Our findings

People we spoke with who lived at the home and their relatives told us that they thought staff were trained to be able to meet the needs of those who lived at the home. They also felt that the staff team were well trained. One person told us, "I have sometimes seen staff doing training when I have visited."

Family members told us they were always kept well informed about any changes in their relative's circumstances. One told us, "If they (the staff) have any doubts or concerns about [name removed] they tell us. She refused to have a flu jab, so the nurse said, 'never mind we will put her on the next batch and try again'." Another commented, "They [the staff] will ring me up and tell me when he is being very aggressive. They tell us when he is in a bad mood or is being abusive to the staff and the other residents. He can be up and stay awake for two days at a time and then sleep for two days." Another said, "They (the staff) rang us last Thursday to say he had a chest infection. Once when he was being very aggressive they rang us and told us."

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 make 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. The application procedures for this in care homes and hospitals are 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 were being met.

Records showed that Mental Capacity Assessments had been conducted for those who lived at Willow Lodge. These had been reviewed each month and specific decisions had been made by a multi-disciplinary team, to ensure any decisions made were in the individual's best interests. Minutes of such meetings were held on people's care files. For example, the decision for a 'Do Not Attempt Resuscitation' (DNAR) order had been made by one individual's GP, in consultation with the next of kin and a representative from the home. However, in one recent case, the GP had not fully completed section 3 of the DNAR form, to indicate if this was an indefinite decision or if the decision needed to be reviewed at any time. This was discussed with the registered manager of the home during our second visit to Willow Lodge, who assured us that she would contact the GP for fully completed forms in line with our feedback and would share best practice with the staff team to ensure any issues where identified sooner.

Evidence was also available to demonstrate that legal authority had been sought for those who lacked capacity and whose liberty was being deprived, in accordance with the written policies and procedures of the home. One relative told us that his wife was being assessed by the mental health team, which had been arranged between the hospital and the home.

During the course of our inspection we toured the premises, viewing all communal areas and a randomly selected number of bedrooms.

We found some areas of the home had recently been redecorated. However, other areas were in need of upgrading and modernising, in order to provide a homely environment and pleasant surroundings for the people to live in. This was discussed with the registered manager at the time of our inspection, who told us that plans were in place for upgrading the remainder of the environment when time allowed.

Areas which needed improvement included:

Some of the doors, door frames, external windowsills and radiator covers were in need of repair or replacing. Some door handles were missing. The seals in the double glazing units in the conservatory were broken and therefore the windows were unclear.

The windowed roof of the conservatory had mould in several places and some of the gaps in the plastic coving were filled with unsightly foam. The wallpaper was torn around the radiator cover in the main lounge. The light shades in this room were full of dead insects and many light bulbs were missing.

Requires improvement

Is the service effective?

We found that the registered person had not ensured that the premises were properly maintained throughout. This was in breach of regulation 15(1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted an enclosed garden, which was neat and tidy. The gardener was working in this area at the time of our inspection. This created a pleasant and safe area for people to use during the warmer weather.

All new employees were issued with relevant information to help them to do the job expected of them, such as job descriptions specific to their role, terms and conditions of employment and relevant policies and procedures. Employee handbooks were supplied to new staff members, which provided them with important information, such as codes of conduct and disciplinary and grievance procedures.

We found completed induction programmes and a wide range of training certificates were retained on each staff member's file. These included learning modules, such as fire awareness, emergency first aid, pressure and continence care, food safety, dementia awareness, the Mental Capacity Act and Deprivation of Liberty Safeguards, infection control, health and safety, safeguarding vulnerable adults and the management of challenging behaviour. The staff training matrix corresponded with the certificates of training available, showing a programme of mandatory training modules for all staff members and additional learning in relation to the specific needs of those who used the service. We were told by the registered manager that all new care staff starting employment in the future would be registered on the care certificate, which is a nationally recognised programme of induction training for care staff.

We saw that notices were displayed in the office identifying staff members who needed to attend forthcoming mandatory training modules, such as moving and handling and fire awareness. During the course of our inspection we looked at training records and the personnel files of three members of staff.

Records we looked at showed that regular supervision and annual appraisal of staff were conducted, which outlined topics discussed with detailed outcomes and agreed actions, as well as identifying training needs and personal development support. This meant there were structured processes in place to assess the work performance and professional development of the entire work force. All staff we spoke with told us that they regularly received formal supervision from the Manager and that they were continuously encouraged and supported to develop their skills and knowledge.

We observed lunch being served in the dining room. At the time of our inspection we saw that the environment was not conducive to a pleasant dining experience for those who lived at the home. There were six people sitting at the bare laminated dining tables. Blue plastic plates containing Lasagne and chips were placed in front of them. People ate their meals with plastic knives and forks. They were asked if they would like salt and pepper, which was put onto their food by the care worker. Plastic tumblers of juice were given to each person when they had finished the hot food. A pudding of strawberry mouse was offered as a dessert. However, everyone appeared to enjoy their lunch, except for one, who did not eat the food provided and was not offered an alternative at that time. We were later told that this was in line with the individual's plan of care and that he did eat his lunch at 2pm, which was his choice and which was recorded on the appropriate chart.'

People we spoke with told us that, in general the food was of a good quality. We noted that people's dietary likes and dislikes were available for staff reference in the kitchen, as well as in the individual care files. Nutritional assessments were conducted for those considered to be at risk of malnutrition. This helped the staff team to make sure these people were supported to maintain a good nutritional intake. The meals offered to people were of good quality and they appeared nutritious. Special diets were catered for, as was required. We noted that beverages were offered to people on a regular basis throughout the day. Drinks were also available for people to help themselves to, which was considered to be good practice. People who required assistance with their dietary and fluid intake were helped by staff in a discreet and gentle manner. Everyone who lived at Willow Lodge was weighed each month and records were retained in the plans of care. This helped the staff team to determine if anyone's weight had fluctuated significantly and if so enabled them to seek appropriate advice.

We were told that the home had developed a good working relationship with community professionals and the care

Requires improvement

Is the service effective?

files we saw showed the involvement of a wide range of external professionals, such as community nurses, psychiatrists, GPs, dentists, opticians, and psychologists. Hospital appointments were also evident.

It was clear that specialised equipment was provided as assessments dictated. For example, people who were assessed as being at high risk of skin damage were supplied with pressure relieving mattresses and cushions. Those who were assessed as at risk of falling out of bed or falling once out of bed independently were provided with alarm mats or bed rails with protective covers, should these be assessed as being the most appropriate type of equipment to reduce the possibility of falls.

It is recommended that the registered manager assesses and reviews the management of meals and meal times in order to provide a more conducive dining experience for those who live at Willow Lodge.

Requires improvement

Is the service caring?

Our findings

In discussion with people who used the service we received positive comments about the care they received at Willow Lodge and the approach of the staff team. When we asked relatives what they thought about the staff team they told us, "Oh the staff are very good", "I think they are all marvellous. They know all about our family. They take as much interest in us as they do in [name removed]" and "They are all great. I have never had a problem or reason to worry."

We observed some positive interaction between care staff and people who used the service. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance.

One relative commented, "They (the staff) really do look after him. They encourage him to eat. They will offer him bacon 'butties' or soup if he is not eating well. They really are wonderful with him. Sometimes he refuses to go to bed. He stays in the lounge all night. They give him coffee and toast, which is good of them." Another told us, "The staff are very caring. They know who needs tactile affection. If she needs a hug she gets a hug" and a third said, "They [the staff] are marvellous. They have endless patience. [Name removed] has no communication. I can't tell what he is saying, but they [the staff] can. They were worried when he went into hospital, in case the staff there would not be able to understand him. They look after him and take it all in their stride, although he can be very aggressive at times."

During the course of our tour around the home we saw one person sitting in the lounge next to an agency care worker used for 1:1 provision, in line with local Clinical Commissioning Group (CCG) guidelines. The resident's blanket, which had covered her legs had slipped down to her knees, exposing her bare legs and incontinence pad. The agency care worker used for 1:1 provision in line with CCG guidelines was not making an attempt to protect the individual's privacy and dignity, until we asked for the blanket to be pulled up, in order to cover her legs.

We saw a temporary member of staff assisting one person to eat their breakfast with a spoon. The spoon was completely full and was proving too much for the individual, as she was protesting. At the same time the registered nurse was trying to administer a tablet to the person from the spoon full of food. This person refused to take the tablet and was clearly unhappy with the care intervention being delivered.

One person, who was sitting in their bedroom on the main corridor, was constantly shouting out and banging on the furniture. Her bedroom door was kept ajar. Staff members attended to her dietary and personal care needs. When we asked staff about this we were told, "She shouts all the time." We examined this person's care file, which stated that they responded to individual attention. However, the plan of care did not identify what this was. One of the inspection team sat with this person for ten minutes, which included holding her hand and talking with her. The effect of this was that she became quiet and less agitated. A member of staff approached whilst we were with her and gave her a biscuit, and told her that she had spoken with her nephew, and that he would be visiting during the afternoon.

We found that the registered person had not ensured that people were consistently treated with dignity and respect. This was in breach of regulation 10(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. Plans of care we saw outlined the importance of respecting people's privacy and dignity and promoting their independence.

Information was readily available about various support organisations which were available and which could be arranged by the home, if needed. These included the Alzheimer's society and the advocacy services. We were told that no-one was using an advocate at the time of our inspection, but we were given two good examples of applications which had previously been made to the local advocacy service. An advocate is an independent person who will act on behalf of someone in supporting the decision making process, to ensure that any decisions made are in the individual's best interests.

Records showed that the home had been accredited with the 'Six steps to end of life care' programme and it was a recognised mentor nursing home for nursing students from the local college.

Requires improvement

Is the service caring?

We observed staff, in general to be patient and caring towards those who lived at Willow Lodge. Staff appeared to know people well and what individuals liked and disliked. We saw staff laughing and joking with people in an appropriate manner and chatting with them in a kind and caring way. Those who lived at the home looked comfortable in the presence of staff members. Relatives told us that their loved ones always look well-presented and that they usually got their own clothes back from the laundry.

The majority of people who lived at the home appeared clean and well cared for. However, two of them were walking round in ill-fitting clothes and one gentleman was unshaven. We saw a member of staff chatting with one person who was distressed. It was clear she knew how to distract him. She quietly asked, "Would you like a banana?" Then added, "You like your bananas, don't you [name removed]?" To this, the individual became less distressed and happily ate his banana.

One person was continually shouting out, "Please help." A member of staff approached this individual explaining that she was just dealing with someone else, but would be back soon. The person continued to shout. Two other members of staff came to assist her shortly afterwards.

Throughout the day we observed staff members interacting with people in a warm and positive manner. We saw a member of staff reassuring one person who was upset, in a meaningful way, which prompted further conversation and enhanced positive interaction, which was pleasing to see. There was evidence of people being offered choices, in relation to what time they got up in the morning and this was confirmed through our observations.

Some people who lived at Willow Lodge occupied shared bedrooms and although privacy and dignity was an integral part of the care planning process, we could find no reference as to how people's privacy and dignity could be respected and promoted when sharing a bedroom with another person.

It is recommended that the plans of care for those who share bedrooms are updated to include strategies which promote privacy and dignity for these particular people.

Requires improvement

Is the service responsive?

Our findings

Relatives we spoke with on the day of the inspection told us that they were happy with the way the home responded to people's health care needs. Comments we received from relatives were all positive. These included: "The home has referred [name removed] to the mental health team. They [the staff] organise doctors when she needs them and also Chiropody"; "The home has referred him for speech therapy. They called in the doctor last Monday to discuss pain relief and to see if the doctor would prescribe thickening products for his food. They have arranged a sight test for him too."

Additional comments from people we spoke with included, "They go the extra mile. It's like one big extended family"; "I think she is in the right place"; "Very nice people we know them all by name" and "First class. It is a great relief knowing she is being looked after and well cared for. Great peace of mind."

The care files we saw were well organised, making information easy to find. However, they varied in quality. In some cases, information was limited and some records were not always up to date or fully completed. Important information was missing from some plans of care. For example, the care file for one person identified that his wife was also in a care home. However, there was no record to show which care home this was or how they would be supported to keep in touch with each other. We asked staff members about this, but they were unsure of the circumstances. We saw that staff interacted with this individual in a polite and pleasant way, but they had little idea about his personal history or his emotional needs.

We found that the registered person had not ensured that the plans of care always reflected people's current needs. This was in breach of regulation 9(1)(a)(b)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw assessments of needs had been conducted before a placement was arranged at the home. Evidence was available of some good examples of person centred care planning where people's preferences were well detailed, so that staff could tailor people's care in line with their personal wishes. For example, some care files we saw included one page profiles, which covered areas, such as, 'What is important to me', 'What people like and admire about me' and 'How best to support me.' Some also incorporated a very detailed synopsis of the person, which included a very detailed history, as well as likes and dislikes. Every care file we saw contained information related to people's physical and mental health needs. Where problems were identified, a plan of care was generated and these covered a wide range of areas, providing staff with clear guidance about people's assessed needs and how these needs were to be best met.

A variety of assessments had been conducted within a risk management framework, which were based on nationally recognised tools. These included risks associated with outings, moving and handling, the provision of keys to bedroom doors, falls, infection control and tissue damage. Evidence was available to show that strategies had been implemented in order to reduce potential harm. For example, where people had been identified as being susceptible to skin damage then appropriate pressure relieving equipment had been provided.

We saw a notice in the office identifying those plans of care, which had been recently reviewed and updated and a list of those still requiring reviews with the person who used the service and their representative, where appropriate. This demonstrated that processes were in place for regular reviewing of care plans, in conjunction with the individual concerned or their family member, so they could take part in making some decisions about the way in which support was being delivered. There was also clear guidance for staff displayed in the office about any allergies which people who lived at the home suffered from. This helped to ensure that any food, medication or other items, which may have caused allergic reactions, were avoided.

A complaints policy was clearly displayed within the home, which incorporated contact details for the relevant authorities. A system was also available for documenting and monitoring complaints received, which included a detailed record of the complaint, set timeframes for responses, the outcome of any investigation, action taken and any changes made in response to concerns raised.

People we spoke with told us that they would be confident in making a complaint to the registered manager or any of the staff members. We noted that the statement of purpose and the service user's guide contained the complaints procedure, so that people had easy access of information

Requires improvement

Is the service responsive?

about how to make a complaint, should they wish to do so. Relatives we spoke with told us they would be able to raise concerns with the manager of the home, should the need arise.

A planned activity programme was in place, which outlined leisure activities for those who lived at Willow Lodge. We were told that an activities co-ordinator was employed at the home for 18 hours each week, which were arranged in accordance with planned activities and the needs of the residents. The programme showed that a person visited to provide exercise classes twice a week and another to do pedicures. We were also told that a singer came into the home once a month to provide musical entertainment.

There was no activity co-ordinator on duty on the day of our inspection, but we were told that she did one-one sessions with people who required more support and on occasion took some people to the shops.

We were told of a system, which had been arranged with some local shops in the town centre, where people who lived at Willow Lodge and who were unable to manage their own finances, but liked to pay for goods themselves were able to exchange imitation money for their shopping. The actual monetary arrangements were subsequently settled by the home. This helped people to assume a feeling of self-worth and responsibility, which was considered to be good practice. Photographs were displayed of keep fit sessions and movement to music, which those who lived at the home seemed to enjoy.

The seasonal newsletter told its readers of forthcoming organised activities, such as a trip to Sefton Meadows for afternoon tea and cakes, the Christmas Fayre, a pantomime, a birthday party and visits from live entertainers.

We observed art work completed by those who lived at the home displayed on the walls of the home and tactile boards had been erected in corridors, which contained a variety of items to distract and occupy those who lived at Willow Lodge. However, on the day of our inspection we saw very little in the way of activities being provided. When we arrived at the home several ladies were having their hair done by a visiting hairdresser. The main lounge had some music playing; otherwise we witnessed no other organised activities, as staff on duty were generally busy assisting people with personal care. However, we were told that when the activities co-ordinator was on duty more stimulation was provided for those who lived at Willow Lodge.

Requires improvement

Is the service well-led?

Our findings

The registered manager of Willow Lodge was onsite most days. We were informed that she was very much 'hands on' and was described as being 'approachable' and 'supportive' and we were told that anyone could discuss any concerns they may have with her at any time. However, the Statement of Purpose, which provided people with important information about the home and the organisation, had not been updated for three years and contained some inaccurate information in relation to the management structure of Willow Lodge. Relatives we spoke with told us that they thought that the home was well run by the registered manager. Everyone knew the manager by name and said she had a very visible presence at the home.

Records showed that some audits had been undertaken each month, which covered areas, such as care planning, infection control, control of clinical waste and medication management. The outcome of audits was rated through a traffic light system, with actions designed for improvements to be made in accordance with the findings. Monthly management reviews were also held based on the five key questions used by the Care Quality commission of safe, effective, caring, responsive and well led. However, many of these systems were ineffective, as failings in the service had not been identified and formally recorded during the auditing and reviewing processes. Therefore, this area was in need of improvement, so that the service could be sufficiently monitored under a continuous assessment process and any improvements needed could be identified and addressed in a timely fashion.

We found that the registered person had not protected people against the risk of unsafe care or treatment, because systems for assessing and monitoring the quality of service provided were not always effective. This was in breach of regulation 17(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a notice in the office, which outlined the Key Lines of Enquiry (KLOE), which is the methodology used by the Care Quality Commission to focus the inspection process. This provided good guidance for the staff team about what people should expect whilst living at Willow Lodge.

Records showed that the home had been accredited with an external quality award. This demonstrated that Willow Lodge was periodically audited by an independent professional organisation. Annual surveys for those who lived at the home, their relatives and staff members had also been conducted. Many positive comments were received from those who returned the surveys. Written comments from relatives included, 'I would say 10 out of 10 for Willow Lodge.'; 'I know that many residents feel secure living here in familiar surroundings. Willow Lodge is very well run by a professional and caring team, who are much appreciated.'; 'The staff are very pleasant, helpful and caring' and 'The home is excellent. We feel lucky our relative is here.' It would be useful if the results of surveys were analysed and displayed in an overall graph format for easy reference.

Minutes of monthly staff meetings were displayed within the home. These meetings allowed relevant information to be disseminated amongst the staff team and encouraged staff members to discuss any topics of interest, or areas of concern within an open forum. We saw evidence that a meeting for registered nurses was arranged for the week following our inspection and we were told that the supplying pharmacist was attending this to give a presentation about medication management.

We were told that meetings for residents and their relatives had not yet been established, but that plans were in place to introduce these in the near future. The registered manager told us that because she was at the home on a daily basis she had regular contact with the residents and their families and this was confirmed by those we spoke with. We were told that discussions were part of everyday life at Willow Lodge and that the registered manager was always visible within the home, which promoted regular contact. Seasonal newsletters were issued to all interested parties. These covered forthcoming events, special occasions and any relevant information which needed to be passed on to all parties concerned.

A wide range of written policies and procedures were in place at the home, such as infection control, fire awareness, medication management, discipline and grievance procedures, equality, diversity and inclusion and health and safety.

It was clear from reading care records and from talking with staff that Willow Lodge worked in partnership with a wide spectrum of other professional agencies.

Requires improvement

Is the service well-led?

We noted that the office space was very untidy and cluttered with various unused items and broken objects. The care files were retained on open shelving in the office and the door was constantly left open, which provided anyone with easy access to these confidential records.

We observed an incident, which should have been reported immediately to the nurse in charge. However, this was not recorded and was not reported. Therefore, accidents had not always been appropriately recorded. We also noted that accident reports had not been consistently kept in line with data protection guidelines, as individual records had not been removed from the main book and had not been retained in a confidential manner.

It is recommended that records are maintained in a confidential manner.

It is recommended that residents and relatives meetings be established and that the results of surveys be produced and displayed in an overall format for easy access.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We found that the registered provider had not ensured that systems and processes had been established to effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **We found that the registered person had not ensured that the premises were properly maintained throughout.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **We found that the registered person had not ensured that people were consistently treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found that the registered person had not ensured that the plans of care always reflected people's current needs.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment, because medicines were not being well managed.**

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered provider had failed to assess and identify risks to the health and safety of people who used the service and had not done all that was reasonable possible to mitigate such risks.**

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We found that the registered person had not protected people against the risk of receiving inappropriate or unsafe care and treatment because infection control practices were poor.**

The enforcement action we took:
Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The registered provider had not protected people's health and safety because they had not ensured that persons providing care or treatment to service users had the competence, skills and experience to do so safely.

The enforcement action we took:

Where we have identified a breach of regulation during inspection which is more serious, we will make sure action is taken. We will report on any action when it is complete.