Willow Home Care Ltd

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Inspection report

Unit 3
Walkmill Business Park
Market Drayton
TF9 2HT

Tel: 01630478913

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Willow Home Care Limited is a domiciliary care service that provides personal care to people living in their own homes. At the time of our inspection, the service was providing personal care support to 42 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
At our previous inspection in June 2021, the provider was in breach of regulation 12, Safe care and treatment and regulation 17, Good governance. At this inspection we found significant improvements. However, the provider remained in breach of these regulations.

Right Support
People raised concerns about late and missed calls. People were placed at risk of avoidable infection because staff did not always apply good practices with regards to infection, prevention and control.

Right Care
During the course of the inspection we identified staff did not have access to detailed risk assessments and the registered manager addressed this immediately. People told us they felt safe whilst receiving a service. All staff had received safeguarding training and were equipped with the skills and knowledge to recognise abuse and to protect people from this. People told us staff were kind, friendly and caring.

Right culture
The provider's governance was not effective to identify the shortfalls found at this inspection. People were involved in staff recruitment to enable them to choose who worked with them. People were cared for by staff who had been recruited safely to ensure they were suitable to work in their homes.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. The provider had recently appointed a new manager who was enthusiastic in developing the service and to be compliant with the regulations ensuring people receive a safe and effective service. Staff had access to supervisions and meetings to keep them abreast of changes to the service. The provider worked with other agencies to provide a specific service for the individual.

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 20 August 2021). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found the provider remained in breach of regulations.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

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

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

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk management and late and missed calls which, had an impact with regards to people's care and support.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Willow Home Care Ltd

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

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

Notice of inspection
This inspection was announced.

We gave the service 24 hours' notice of the inspection. This was because we wanted to make sure the registered manager would be on site to support the inspection.

Inspection activity started on 19 October 2022 and ended on 26 October 2022. We visited the location's office on 24 and 26 October 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and four relatives about their experience of the care provided. We spoke with one care staff, a care coordinator, the director and the registered manager.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Our previous inspection in June 2021 found the provider's risk management did not ensure the safety of people using the service and was in breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was issued with regards to this breach.

At this inspection we found the provider had taken some action to improve risk management but were not fully compliant with the regulation.

Assessing risk, safety monitoring and management
• People we spoke with were not entirely sure whether they had a risk assessment in place.
• A staff member told us information relating to potential risk could be found on the 'Birdie.' This is an application (app) where information relating to people's care and risk management was held. Paper copies of care plans and risk assessments were maintained in the office which, provided detailed information about people's care needs and how to meet them safely. However, this level of information was not contained on the 'Birdie' app which was accessible to staff. This meant people were at risk of not receiving safe care and support. On the second day of our inspection, the registered manager had taken action to ensure staff had access to relevant information.
• Personal emergency evacuation plans (PEEP) were in place. However, we found one PEEP provided incorrect information relating to the support the individual would require to safely leave their premises in the event of an emergency which, the registered manager acknowledged.
• Staff and the registered manager identified the same person required additional staff to meet their needs safely. The registered manager told us they were awaiting an occupational therapist assessment. However, in the interim period the risk assessment had not been reviewed. This meant the person could be at potential risk of harm.

Using medicines safely
• At our previous inspection we found shortfalls with the management of medicines which, placed people's health at risk of potential harm. At this inspection records showed a paramedic had raised a safeguarding alert about a person not receiving their medicine.
• One care record showed the person had been prescribed eye drops to be applied when required. However, the name of the medication was not identified, and this information was not recorded on the 'Birdie.' The care coordinator was unable to confirm whether the person had received this treatment or not.

• Insufficient systems were in place to ensure people had received their medicines as prescribed. For example, the care coordinator would check the 'Birdie' to see if staff had administered medicines. However, there were no follow up checks to ensure these medicines had been administered as shown on the 'Birdie.'

Preventing and controlling infection
• One person told us, "Staff don't wash their hands, they put their gloves on and don't wash their hands when they take their gloves off. They don't wear masks now, not for months." Other people raised the same concerns.

Risk management, the safe management of medicines and infection, prevention and control practices needed further improvements to be compliant with the regulation. Hence, the provider remains in breach of regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• A staff member told us they had access to personal protective equipment (PPE) and had received infection, prevention and control training and staff training records confirmed this.
• The registered manager told us during spot checks infection, prevention and control (IPC) practices were observed to ensure the safety of people. During these observations staff had been observed to be following safe IPC practices and wearing appropriate PPE.
• We observed the provider had an infection prevention and control policy in place which was up to date.

Staffing and recruitment
• Three people told us they had experienced missed calls and were left without support. One person told us, "I was worried when no one turned up. It was difficult but I washed myself and went to bed." Another person said, "Some days they (staff) don't turn up and then I struggle to wash myself. It's happened a few times." Documents held within the office showed one person had a missed call which lead to them sustaining a fall. There was also an incident where the 'Birdie' identified a missed call, but this was not acted on.
• Two relatives told us on rare occasions not enough staff were provided to care and support their relative. One relative told us, "I have to step in and help the staff out because [Person's name] needs the use of a hoist." Another relative said, "I usually go out when the staff arrive but I can't do that if only one care staff turns up because I have to help out."
• People told us times of calls were inconsistent and this worried them. Two people told us; due to late calls they did not receive support with their continence needs in a timely manner.
• The director told us they currently had enough staff to meet people's assessed needs and staff recruitment was ongoing. The registered manager told us concerns relating to missed calls and insufficient levels of staff attending calls was prior to their appointment and if there was ever a time where there was a shortage of staff, the office staff would assist.
• People told us they did not always know what staff would be visiting and for most people this was not a problem because they knew all the staff. One person told us. "I have different carers, and this does not bother me, and I know them all, they are like my friends." However, one person told us due to their relative's health condition, a change of staff caused them to become anxious and agitated. They told us this had been discussed with the registered manager who would now contact them with any changes to the staff rota to allow them to discuss this with their relative and reassure them.
• Staff told us before they commenced employment with Willow Home Care Limited, a Disclosure Barring Service (DBS) check was carried out and two references were obtained. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

• Staff had received safeguarding training to equip them with knowledge of different forms of abuse and how to safeguard people from this. People told us they felt safe using the service. One person told us, "I do trust the staff, they are very good I haven't had any upset with them, we have a laugh." Another person said, "I feel safe, they [staff] always seem confident, kind and friendly and look after me well." A different person told us, "I feel very safe, it's the way the staff come and make me comfortable and that makes me feel safe."
• Discussions with a person's relative confirmed their relative had mental capacity and this was confirmed by the registered manager. However, a record for 'Consent for care and support' identified the person lacked capacity. This could lead to the person's choices not being acknowledged.
• The registered manager had obtained evidence where people had a court of protection order in place.

Learning lessons when things go wrong
• During discussions with the director and the registered manager they told us about the importance of addressing concerns straight away to avoid this becoming a complaint. The director said, "We hold telephone conversations and go out to visit people when they have shared any concerns with us. We have learnt the importance of contacting people to tell them if we are going to be late, to reduce anxiety."

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question remained the same.

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

At our previous inspection in June 2021, the provider was in breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had taken action to improve their governance.
At this inspection we found the provider had taken some action to improve risk management but were not fully compliant with the regulation.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• We received different information from people with regards to quality checks. Some people told us they had never been asked whether they were happy with the service they received. People and staff told us spot checks were very infrequently carried out.
• The provider's governance was not entirely robust to ensure care and support was delivered on time and that calls were not missed. One person told us, "The service is good apart from when they don't turn up." Where calls were late or missed this had a negative impact on people's lives. For example, two people told us about the indignity of being incontinent because their call was so late. Monitoring systems were not effective to ensure people always received their medicines as prescribed. Quality checks of care records did not identify; the personal emergency evacuation plan for one person did not provide staff with relevant information; the absence of the name of a medicine and directions for administration for one person. Where safeguarding alerts had been made, monitoring systems did not identify the absence of information relating to action taken to safeguard the individual.
• Although, the registered manager had taken prompt action to ensure the 'Birdie' provided staff with relevant information relating to people's care and support needs, this was only actioned when we brought this to their attention. People raised concerns that staff did not always use PPE and spot checks did not identify these practices.

The provider's quality monitoring systems were not entirely effective to ensure people received an effective service and they continued to be in breach of regulation 17, Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The provider had recently appointed a new manager who registered with us in September 2022. Since their appointment we have received positive feedback from the local authority with regards to the reduction of

concerns received. A staff member told us the registered manager was approachable and professional.
• We observed the rating of the last inspection visit was displayed in the office. The registered manager was aware of their responsibility of when they were required to notify us of any incidents that had occurred.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• All the staff we spoke with demonstrated a caring attitude about the people they cared for. We found care plans were person-centred.
• People were very complimentary about staff's approach and caring attitude.
• The registered manager had a positive and improvement-driven attitude in providing an inclusive culture. They told us, "This is a family run business, anyone who comes through the door are part of the Willow family and everyone gets treated the same."
• The registered manager was visible in the service, approachable and took a genuine interest in improving the quality of service provided to people.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• Both the registered manager and the director demonstrated a good understanding of the duty of candour. The director acknowledged shortfalls within the service and with the appointment of the new registered manager was driven in improving the quality of the service delivery.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff meetings were carried out to ensure staff were aware of any forthcoming changes to the service.
• The registered manager told us staff had access to supervision and the records we looked at evidenced this. This ensured staff were supported within their role.
• The director told us people were involved in staff recruitment. This gave people the opportunity to choose who they felt would be suitable to meet their specific needs.

Continuous learning and improving care
• The director told us refresher training had been provided to all staff to enhance their knowledge and skills in areas where they had past concerns. The registered manager told us all staff had received relevant training in relation to people's specific health care needs.
• The registered manager acknowledged the shortfalls identified during the inspection and was confident in improving the service delivery.

Working in partnership with others
• The provider worked with other agencies in providing a service for people. These included GPs, occupational therapist and district nurses.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Improvements were required to ensure staff always have access to relevant information relating to risk management and that personal emergency evacuation plans provide accurate information relating to the support an individual would require to evacuate their premises in an emergency. To ensure records detailed prescribed medicines and how and when they should be administered.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's governance needs to be reviewed to ensure monitoring systems are effective, so people do not experience late or missed calls. To ensure quality monitoring systems review the 'Birdie' application so staff have access to relevant information about people's care and support needs and how to manage any potential risks. To ensure where safeguarding referrals have been made, practices are reviewed and monitored to avoid any reoccurrence.