Willows Lodge Limited

Willows Lodge Care Home

Inspection report

82-84 Calcutta Road
Tilbury
Essex
RM18 7QJ

Tel: 01375852020

Date of inspection visit:
23 August 2023

Date of publication:
11 October 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Willows Lodge Care Home provides accommodation, personal care and nursing care for up to 70 older people, people living with dementia and those who require nursing and palliative care. The service consists of 3 units: Poppy Unit for people living with dementia, Buttercup Unit for people who require nursing and palliative care and Rose Unit for people who require residential care. At the time of the inspection there were 63 people living at the service.

People's experience of using this service and what we found
People's care was not always delivered safely. Information relating to people's individual risks was not always recorded, up-to-date or did not provide enough assurance that people were safe.

Suitable arrangements were not in place to ensure the proper and safe use of medicines. The staffing levels and the deployment of staff was not suitable to meet people's care and support needs. Training was not always up to date.

People were not protected by the prevention and control of infection. Staff did not always receive adequate training and supervision.

People and their relatives told us they were treated with care and kindness. However, the care provided was not always person-centred.

Not all care plans contained enough information to ensure staff knew how to deliver appropriate person-centred care. People were not supported or enabled to take part in regular social activities that met their needs.

Staff were aware of who they were accountable to and understood their roles and responsibilities in ensuring people's needs were met. The registered manager had good links with a number of health and social care professionals and this helped to ensure people's needs were met.

Management and staff treated people with kindness and compassion. Positive relationships had developed between people and staff. However, people's experiences of care varied considerably.

The new management structure was committed to improving the service and creating a positive and inclusive culture at the service.

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

Rating at last inspection
The last rating for this service was good (published January 2020)

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements.

Enforcement and recommendations
We have identified breaches in relation to safe care and treatment, staffing, nutritional and hydration needs and good governance at this inspection and made a recommendation in relation to the Mental Capacity Act and care plans and risk assessments.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we inspect next.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Willows Lodge Care Home

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of 2 inspectors. The team also included a nursing advisor and 2 Expert by Experiences'. The Expert by Experience's completed telephone calls to people's relatives. 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
Willows Lodge Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Willows Lodge Care Home also provides nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.
Inspection activity started on 22 August 2023 and ended on 31 August 2023. We visited the service on 23 August 2023.

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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people who used the service and 16 relatives about their experience of the care provided. We spoke with 10 members of staff, including the registered manager, deputy manager and director.

We reviewed a range of records. This included 9 people's care records and 5 people's medicines records. We looked at 5 staff files in relation to recruitment and staff supervision. We looked at the provider's arrangements for managing risk and medicines management, staff training data, complaint and compliment records.

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 good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- The arrangements to safeguard people from risks relating to preventing and controlling the spread of infections were not being effectively managed.
- Personal protective equipment (PPE) seen in one area of the service was not stored in line with good practice guidelines. All staff had access to PPE, however, some staff were observed removing their PPE in the corridor and not washing their hands before proceeding to another resident. This presented an infection prevention risk.
- People's hoist slings were not stored safely. We saw slings hanging over hoists and storage trolleys in the bathroom on the first floor. There were slings kept on a hoist in the corridor and slings on the floor in the laundry room. Staff were not following best practice guidance to control the prevention of infection.
- The laundry room, bathrooms and trollies were unhygienic. A communal bathroom was being used to store wheelchairs and storage trolleys. There were used razor blades, gloves, an empty jug and a cup left on the sink. We also found toiletries stored in the bathroom which was a cross infection risk.
- A laundry bag containing un named knickers was found in the laundry room. The registered manager was unable to clarify why they had been kept there.

Using medicines safely

- The systems and processes in place to safely administer and record medicines use were not always safe. Medicines were not always being stored safely in line with manufacturers recommendations and this placed people at risk of potential harm.
- The Controlled Drugs cupboard on the nursing unit was locked however, all other cupboards containing prescribed medication was unlocked and left over medication was found on the floor and on tables.
- Some medication was kept in a fridge on the Nursing unit. The fridge did not have a thermometer so temperatures were not being recorded which meant there was a risk medicines were not safe to administer to people.
- We found 8 opened sharp bins on the floor in the medicine room. This could cause potential infection and meant staff were not following policies in place.
- We looked at the Medication Administration Records [MAR] for some people living at the service and found improvements were required to the service's medication practices.
- Staff had signed on MAR charts for some people indicating medication had been administered, however, this did not reconcile with the amount of medication remaining.
- When required medication [PRN] protocols had not been updated or reviewed.
- Medication audits were completed regularly but had not identified the above discrepancies.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Although there was limited impact for people using the service, not all risks to people's safety and wellbeing were assessed, recorded or provided enough detail as to how identified risks should be managed and mitigated. This placed people at potential risk of not having risks to their safety met in an appropriate and safe way.
● Where a person required a sensor mat due to high risk of falls, there was no sensor mat in place and they had no access to a call bell. Some sensor mats were kept underneath people's bed. Staff told us that night staff may have moved them.
● People had their call bells unplugged or the call bell was not within reach. This meant people were unable to access the support they required.
● Not all environmental risks to people using the service had been identified. At the last inspection, we found 10 freestanding wardrobes were not secured to the wall. At this inspection, we found multiple freestanding wardrobes still not secured to the wall. This meant there was a risk of the wardrobes falling causing possible injury to people and others.
● Risks relating to the service's fire arrangements were monitored and included individual Personal Emergency Evacuation Plans [PEEP] for people using the service. However, some of the information was not accurate or up-to-date. For example, a person's PEEP stated they can become unsteady when walking but on the day of the inspection, we observed the person was immobile.

Systems had not been established to ensure care and treatment was provided in a safe way for service users. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service managed accidents and incidents affecting people's safety well. Staff recognised incidents and reported them appropriately and managers investigated incidents. Lessons learned from incidents were shared and discussed at team meetings and used to improve people's care.

Staffing and recruitment
● The registered manager ensured there were sufficient numbers of staff available to meet the needs of people. However, we looked at the home's dependency tool and found this had not updated to reflect people's current support needs. On the day of the inspection the deployment of staff was observed to be unsuitable and not in line with people's support needs.
● We observed staff to be task focused and there were not enough staff available to provide prompt support.
● We observed long periods of time where staff were unavailable to support people. A call bell was buzzing for 32 minutes and an inspector had to inform a member of staff to attend.
● Staff told us, "We are always short staffed. We have discussed this with management many times but they don't seem to take it further.'' Another member of staff told us, "If 2 of us are supporting a person with personal care and the other is with another person, we just have to let the call bells ring because we physically cannot get to them."
● People's and relatives' comments relating to staffing levels were variable and implied there were on occasions insufficient staff available to meet people's needs. A person told us, "Between midnight and 5am is a time of no action'' and a relative told us, "There have been times when [relative] had required continence care between this time but was not attended to". A person told us, "Willows is a ''don't care'' home as opposed to a ''care'' home and I am in the wrong place''. Another person told us, "Some people only see staff for a pad change and being fed. It is not a good life".

Effective arrangements were not in place to ensure there were enough staff available to meet people's

needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were safely recruited in line with the requirements. However, this process could be more robust as some of the application forms and interview notes were not fully completed, and some references were not always checked for verification.

Systems and processes to safeguard people from the risk of abuse

● People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse.

● Staff had received training in safeguarding and knew how to raise any concerns. Staff told us, ''I know how to report any form of abuse and I would take immediate action.''

● The registered manager understood their legal responsibilities to protect people and share important information with the local authority and CQC.

Visiting in care homes

● People's relatives were supported to visit the service and confirmed there were no visiting restrictions in place. A relative told us ''We can visit whenever we want to. There is an open-door policy. We don't have to tell them we are coming to visit [relative]. I come and visit all the time.''

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff told us they were supported with an induction when they first started working. However, no information was available on staff files to demonstrate a robust induction had been completed to enable staff to carry out their role and responsibilities effectively. Following the inspection, the registered manager sent a copy of completed staff induction.
- Staff did not receive regular support in the form of a supervision. Staff told us they do not have regular supervisions and this information concurred with the home's supervision matrix. This meant there were no effective arrangements in place to monitor staffs' practice, performance and professional practice.
- Although there was no impact for people using the service, staff training records showed not all staff employed at the service had received all mandatory or refresher training. Not all staff had received end of life care training.

Suitable arrangements were not in place to ensure all staff employed received appropriate training, a robust induction or regular supervision. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not always supported to eat and drink in a safe and timely manner. Staff told us, "We serve people in the dining room with their lunch and dessert and then take the trolley around to deliver food to people who are in their rooms." On the day of the inspection we observed lunch. We observed very little supervision during lunch and staff were unavailable in the dining room to prompt people who needed additional support.
- A person's care plan stated they were at high risk of malnutrition and dehydration and staff should assist at mealtimes with prompting and encouragement. However, we observed staff had left the person's food on a table by their bed. The person did not eat their food and their call bell was on the floor so they were unable to summon help.
- The service did not sufficiently monitor or manage the risks associated with poor hydration and nutrition. For people who were on a specific fluid regime, a chart was completed with a daily fluid target. However, we found, there was inconsistent recording. The records showed a person had finished their drink but the inspector observed a member of staff removing a full glass from the persons room. This meant staff are not recording fluids accurately and this had not been picked up by the senior carer as part of their daily monitoring. Therefore, people were at risk of receiving unsafe care and support. We discussed our findings with the management team who said they would ensure the records were completed accurately.

● Comments about the quality of meals varied. A relative told us, "The food isn't very good, [relative] doesn't like most of the meals. They have things like chicken nuggets and fish dippers, its food for kids, [relative] would never eat something like that." A person told us, "The food is ok."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were supported to meet their nutritional and hydration needs. This was a breach of regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's care plans and risk assessments were not always personalised and support was not always in line with people's care plan guidance. For example, 1 person's care plan stated they required assistance of 2 staff to transfer by standing transfer into a wheelchair. However, during the inspection, we observed the person was in bed and staff told us they were no longer weight bearing.
● There was a lack of clear guidance and key information in care plans to enable staff to deliver the right and consistent support people needed when distressed.
● Some people's personal history was either not recorded or sparse. Staff were not provided with a good amount of information about the person's past life to help understand them and initiate conversation. For one person, whose care plan identified their social, religious and cultural needs, likes and dislikes, there was no evidence in the daily log that these had been met.
● Improvements were required to ensure completed care plans and risk assessments were person centred and included how risks to people were to be mitigated and reduced. Some information was generic and not personalised to the individual people using the service.

We recommend the provider refers to best practice guidance to ensure that care plans and risk assessments contain the information needed to provide person centred care, are kept up to date and under regular review.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The registered manager told us they were in regular contact with the GP and if necessary, they would visit the service. We saw evidence of this in people's daily record's.
● A clinical nurse was at the home on the day of the inspection carrying out a 6 monthly review.

Adapting service, design, decoration to meet people's needs
● Willows Lodge Care Home is arranged over 3 floors, with communal lounge areas and dining rooms on each floor. People had access to landscaped gardens and grounds.
● People had personalised rooms which supported their individual needs and preferences.
● There was an on-site maintenance person who was completing routine maintenance.

Ensuring consent to care and treatment in line with law and guidance
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 take 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.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Staff had variable levels of understanding of the Mental Capacity Act 2005, including Deprivation of Liberty Standards. Some staff were unable to define the Mental Capacity Act and its importance.
- Staff were observed during the inspection to uphold people's rights to make decisions and choices.
- Where people had been assessed to lack capacity to make significant decisions about their health and welfare, records did not routinely reflect who had been involved to make decisions in their best interests. Some records did not contain evidence of who was involved during the decision making process.

We recommend the provider refers to best practice guidance to ensure that staff have a good understanding of the Mental Capacity Act principles and how these should be applied.

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 good. At this inspection this key question has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The quality assurance and governance arrangements in place were not always effective in identifying shortfalls in the service.
- The registered manager had not always ensured that an accurate, complete and contemporaneous record was maintained in respect of people who used the service. Daily records of care were not maintained clearly to state the care people received and the actions taken. This put people at risk of harm.
- Risks to people's safety and wellbeing were not being recorded, monitored, and managed effectively. There was no audit of care plans and risk assessments to ensure people's needs had been assessed, recorded and were being met if detailed in their care plan. This meant robust processes were not in place to monitor the quality of the service, risks to people's safety and maintain complete and up to date records in respect of the decisions taken about each person's care and treatment.
- Not all staff spoken with felt supported and valued by the management. Some members of staff told us they were wary about raising concerns with the registered manager as they did not feel these would be addressed effectively.
- The registered manager told us they did not receive a formal induction when they first started their role. The registered manager told us they required additional support and this was discussed with the director on the day of the inspection.

We found no evidence that people had been harmed however, effective systems to monitor and improve the quality of the service were not in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During the inspection, the director told us they would be providing additional support for the registered manager and are recruiting an additional member of staff to support the registered manager.

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

- Staff meetings were held monthly. We reviewed minutes and saw they included updates about people who used the service as well as reminders about training. However, there were no action plans completed to evidence how issues raised were to be addressed, dates to be achieved and if actions had been resolved or remained outstanding.
- The registered manager sent surveys to relatives and people using the service to gather feedback about

the service. The results were analysed for themes and trends.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Some staff were positive about working at the service and promoting good outcomes for people. Staff told us, "The manager is very supportive and approachable, and we all work well together. I like my job and I enjoy supporting people.'' However, some staff told us, ''I don't feel the service is managed well. We don't often get the support we need.''

● Whilst staff were caring and kind, care and support was task and routine led; and not as person-centred as it could be. We observed during the day that staff did not spend time with people, other than providing personal care or doing a task.

● The registered manager understood their responsibility under duty of candour. Duty of candour requires providers to be open and transparent with people who use their services and other people acting lawfully on their behalf in relation to care and treatment.

Working in partnership with others

● The provider worked in partnership with a number of different health and social care professionals including the local authority and local healthcare services.

● Staff were aware of the importance of working alongside other agencies to meet people's needs and liaised with other healthcare professionals such as the GP and pharmacy when required.

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
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were supported to meet their nutritional and hydration needs. This was a breach of regulation 14 (Meeting nutrition and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Effective arrangements were not in place to ensure there were enough staff available to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to ensure care and treatment was provided in a safe way for service users. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Warning notice served

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people had been harmed however, effective systems to monitor and improve the quality of the service were not in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

The enforcement action we took:

Warning notice served