Victorguard Care plc

Willow Bank Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

The inspection of Willow Bank Care Home took place on 30 May and 7 June 2018. We previously inspected the service between 6 December 2017 and 18 January 2018; at that time we found the registered provider was not meeting the regulations relating to person centred care, safe care and treatment, meeting nutrition and hydration needs, fit and proper persons employed and good governance. We rated them as inadequate and placed the home in special measures. A service is then allowed time to address the shortfalls we have identified before we re-inspect them. We brought the inspection date forward as we were concerned people were at risk harm. The purpose of this inspection was to ensure people were safe and to see if significant improvements had been made since the last inspection to the quality of the service currently being provided for people.

Willow Bank Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Willow Bank accommodates a maximum of 59 people. The home provides care and support to older people in two units, one of which (Elizabeth Wing) provides personal care for people living with dementia. There were 47 people living at the home at the time of the inspection.

The service had a manager in place but at the time of this inspection they were not yet registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection, we identified a continuing breach of regulations related to dignity and respect, nutrition and hydration and good governance. We found the previous breaches to regulation relating to person centred care, safe care and treatment and fit and proper persons employed, had been addressed.

Improvements were needed to the management of fire safety. Fire training was not up to date and there was no equipment in place to enable staff to evacuate people in the event of an emergency.

There had been concern regarding the management of people's skin integrity. We saw a number of actions had been implemented by the manager including staff training and taking steps to improve communications with the district nurse team,

Staff recruitment was safe. People told us there were sufficient staff but some relatives were concerned that recent changes to the allocation of staff at the home may impact upon people's care. Additional staffing support had been provided to Elizabeth Wing since the last inspection.

Medicines were not always stored safely but action was taken at the time of the inspection to address this. Suitably trained staff administered medicines, in a kind and caring manner. Staff administered medicines as prescribed but we found the management of creams still needed to be improved.

People were mainly complimentary about the meals, although we found not everyone's nutrition and hydration needs were met. Where staff recorded peoples diet and fluid intake, these records were not accurate.
Staff received an induction when they commenced employment at the home. Supervision was ongoing but we found staffs training was not up to date.

People were able to access other healthcare professionals as needed although the district nurses they said they were concerned communication within the home was effective.

Decision specific capacity assessments and best interest's decisions were evident in people's care plans, but people were not always supported to have maximum choice and control of their lives. There was a lack of evidence to suggest people and their families were involved in the care planning process. Where people had limited verbal communication, alternative methods of communication were not used. We have made a recommendation about the Accessible Information Standard.

Staff did not always treat people with dignity and were not always respectful to people or their belongings. Confidential information was not always stored securely.

Care records were person centred but were not always a reflection of people's current care and support needs. Where changes had taken place, staff did not always update all the relevant documentation, where action had been taken this was not always documented.
There were a range of activities provided for people to participate in.

Complaints were addressed by the manager but low-level concerns were not routinely recorded by the manager. Feedback was obtained from staff, people who lived at the home and relatives through meetings and questionnaires.

There was an audit plan in place outlining when specific audits were to be completed. Audits were also completed by the quality manager and an external consultant. Internal audits were not always completed in a timely manner and an action plan submitted by the manager did not detail the issues to be addressed or how they were to be actioned.

The governance systems were still not sufficiently robust had not yet addressed all the regulatory breaches identified at the previous inspection.
This service had been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us improvements have been made and are no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. However, we found a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014; you can see what action we told the provider to take at the back of the full version of the report.

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.

Improvements were needed to improve fire safety.

Staff recruitment was safe. Staff were very busy but changes to staffs shifts and work allocation had recently been implemented.

Medicines were not always stored safely. Records relating to the applications of creams were inconsistent.

People told us they felt safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's nutritional and hydration needs were not always appropriately met.

Staffs' training was not up to date.

People received input from other healthcare professionals.

Care records included evidence of capacity assessments and best interests decision making.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect.

Records were not always stored confidentiality.

People were encouraged by staff to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were person centred but they were not always an accurate reflection of people's current care and support needs.

People were supported to engage in a programme of activities at the home.

Complaints were investigated and acted upon but low level complaints were not recorded.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was a manager in post but they were not yet registered with CQC.

The systems of governance were not robust and had not yet addressed regulatory failing identified at our previous inspection.

Meetings were held with relatives, people who lived at the home and staff.

Willow Bank Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by the receipt of a high number of notifications relating to people's skin integrity and the development of pressure ulcers. This inspection commenced on 30 May 2018. The inspection team consisted of two adult social care inspectors, a specialist adviser 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. The expert by experience on this occasion had experience of both accessing and working in health and social care. Two inspectors also visited the home on 7 June 2018. Both days of the inspection were unannounced.

Prior to our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We contacted commissioners of the service, safeguarding and the community nursing team to ascertain whether they held any information about the service. This information was used to assist with the planning of our inspection and inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We also used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight people who were living in the home and eight visiting relatives. We also spoke with the two directors of the organisation, the manager, deputy manager, clinical lead and fourteen other staff. We reviewed four staff recruitment files and fourteen people's care plans as well as a variety of documents which related to the management and governance of the home.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we rated this key question as 'Inadequate'. We identified concerns regarding staff recruitment and deployment and risks to people's safety were not always mitigated. At this inspection we found improvements had been made but there were still many areas where further work was needed.

The management of fire safety was not sufficiently robust.

Each of the care files we reviewed contained a personal emergency evacuation plan (PEEP). This is a document which details the safety plan in the event the premises must be evacuated. A copy of people's PEEP was stored centrally to ensure they were readily accessible in the event of an emergency. The manager told us these were audited weekly to ensure there was an up-to-date PEEP for every person who was living at the home. We noted one person's PEEP recorded, 'will they need an evacuation aid – no', this contradicted their mobility care plan which recorded staff sometimes had to support them with a stand aid. We brought this to the attention of the manager. At the time of the inspection there was no equipment in place to assist staff to evacuate people from their bedrooms in the event of a fire or other emergency. We spoke with the manager following the inspection and they told us appropriate equipment was now in place.

Fire training was not up-to-date although staff were able to tell us what they would do in the event of the fire alarm being activated. The manager told us annual fire training was mandatory for all staff. We saw of the 59 staff listed on the training matrix 16 had not updated fire training within this timescale. When we spoke with one of the directors they told us simulated fire drills had been completed in the past, they said they had plans to re-visit this in the coming months.

The fire risk assessment for Willow Bank had been completed by the manager. It is a legal requirement for all premises to have a fire risk assessment, which must be completed by a suitably competent person. We were concerned the manager did not have the relevant knowledge to enable them to complete a robust assessment. We spoke to both the manager and one of the directors about this.

This demonstrated systems of governance were not sufficiently robust as these shortfalls had not been identified by the registered provider. This demonstrates a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, we notified the fire service about our concerns regarding fire safety at the home. The manager told us a fire officer had subsequently visited the home and their recommendations were being actioned.

On the first day of the inspection we noted access to the laundry on the first floor and a sluice room on the first floor was not restricted. It is important vulnerable people are not able to freely access areas where chemicals are stored and used and where they may be at risk of scalding from very hot water. We brought this to the attention of the manager. When we visited on the second day, a coded access lock had been put on the laundry door, a lock to the sluice door was fitted shortly after the inspection.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the electrical and gas systems. We saw cleaning schedules were in place and all products subject to the Control of Substances Hazard to Health Regulations [COSHH] were securely stored.

We reviewed the moving and handling information in five people's care files. The information in four of the files was detailed and reflected the care and support people received. Where people needed a hoist, records included details of the sling and which loops were to be used. However, it was clear staff were not always aware of the instructions in people's care files. One person's care plan instructed staff to use a red sling, which we saw staff using, however, we heard a staff member say, "Do you know where the yellow sling is? We need to move [name of person]. This one will do." We then saw them use a red sling to transfer the person. Using the correct sling reduces the risk of harm to both people and staff.

On the first day of the inspection we observed staff transfer a person using the hoist. Their care plan, noted 'can at times walk but most of time needs assistance from staff and stand aid'. We identified their needs had changed very quickly, therefore we checked their care plan again on the second day of the inspection. We saw a risk assessment dated 1 June 2018 recorded the person now needed a hoist and sling for transfers. But two care plans had not been updated and still recorded the person walked with a frame. It is important that when a person's needs change, all relevant care records are updated to reflect their current care and support needs so care is delivered safely.

Care files contained a range of risk assessments, for example, moving and handling, skin integrity and falls. Where people were at risk of falls, steps had been taken to reduce future risk, for example, bed safety rails, low height beds and sensor mats had been put in place.

The manager completed a monthly falls analysis. This analysed the times and location of falls as well as the action taken to reduce the potential for future accidents. The manager explained they had recently extended the audit process to enable them to assess whether any action implemented had been effective. This demonstrated there was a system in place to reduce risk to people's safety and welfare.

Prior to this inspection we received a high number of notifications, submitted by the manager, in relation to people's skin integrity and the development of pressure ulcers. Each of the care files we reviewed contained a skin integrity risk assessment which had been reviewed at regular intervals. We spoke with two staff about pressure care management at the home. They were able to tell us about the signs they would look out which may indicate a person was at risk of developing a pressure ulcer and what action they would take to address this.

Action was being taken by the manager to address the concerns around pressure management at the home. The manager completed a monthly pressure ulcer audit, this noted the incidence of pressure ulcers and the action being taken. They also showed us a further action plan which listed a number of actions, the majority of which had been actioned. The manager told us two staff had very recently completed training about pressure ulcers. They said the staff would now be able to cascade their knowledge to other staff as well as promoting good practice within the home. Further training had also been arranged with the district nurse at the end of June.

We spoke with two visiting district nurses. They both said recent improvements had been made in relation to the care needs of people at risk of skin breakdown.

At the last inspection we concluded staffing numbers and deployment of care workers needed to be reviewed to ensure care workers were available to offer support in a timely way. At this inspection people

said; "There is enough staff", "When I buzz they do come. if it is not something they can do for me straight away, they will tell me there is a little wait but they will be back. They do come back" and "There is enough staff. They are always here for me, if I need them I can buzz. They always attend to me." Two of the relatives we spoke with also spoke positively about the number of staff on duty.

At the last inspection we found the care staff on the residential unit had been split into three teams. Elizabeth wing had its own designated staff team. On this inspection we found the manager had, following consultation with staff changed the rota and shift patterns at the home on a one month trial basis. This meant the majority of staff now worked a12 hour shift and were no longer based on a specific unit but were allocated their place of work each morning. The manager told us that hopefully this would provide a more flexible service.

Most staff we spoke with told us they were happy with the new rota system. Two staff felt it may not provide continuity of care to the people living on Elizabeth Wing. This concern was also echoed by two of the relatives we spoke with. One relative said, "I am not happy with the change, people need consistency of staff who know them well." On the second day of the inspection we found two of the three staff working on Elizabeth wing had been employed at the home for less than a month. A discussion was held with the manager regarding the need to ensure the skill mix within the staff teams was maintained in line with people's assessed needs.

At the last inspection we also found the registered provider had introduced a new 'Team leader' post to improve communication within the home. On this inspection we found the new post had become embedded in the senior staff structure although a job description for the post had still to be completed. A discussion was held with the manager regarding the need to ensure staff were fully aware of the roles and responsibilities to enable them to carry out their roles effectively.

We were concerned that on the residential unit staff were extremely busy on both days of inspection as the majority of people living on unit required two staff to assist them with their personal care needs. This was discussed with the clinical lead who confirmed they had recently discussed staffing levels on the unit with the registered provider and manager with a view to increasing the number of staff on duty at peak periods of the day.

Fourteen people were living on Elizabeth Wing. There were three staff and a kitchen assistant assigned to work on the unit between 8am and 8pm. One of the staff we spoke with told us the kitchen assistant was a recent addition to the staffing numbers on the unit. They were positive about the improvements this extra staff member had made to the care and support people received.

Our previous inspection identified a breach in regulation relating to fit and proper persons employed. On this inspection we looked at four employment files and found improvements had been made to the recruitment process.

Peoples medicines were not always stored safely. Medicine trolleys were stored in the clinic room. Staff monitored and recorded the temperature of both the clinic room and the medicines fridge to ensure peoples medicines were stored appropriately. On both days of the inspection we saw the trolley for Elizabeth Wing was taken from the clinic room and was kept in the kitchen area of the unit. This room was warm, the temperature was not routinely monitored and staff stored the trolley adjacent to the hot food trolley. It was clear from our conversation with the manager, they expected staff to return the trolley to the clinic room between medicine rounds. The team leader informed us the trolley remained in this area from 7.30am to 10pm when it was returned to the clinic room.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines (CD's). We noted the cabinet used to store these medicines was stored in a small internal room adjacent to the clinical room. The room was unventilated and was very warm, the temperature is not monitored. We raised this with the deputy manager. One the second day of the inspection the registered manager told us the cabinet had been moved out of this room.

We reviewed a random sample of ten medicine administration records (MAR's). Each MAR we reviewed had been fully competed with no omissions or errors detected. We saw three people were prescribed medicines which needed to be taken before they ate breakfast. Records evidenced staff were adhering to this instruction. We also checked two people's CDs, we saw the stock tallied with the recorded number of administrations and records showed they had been administered as prescribed. When people were prescribed 'as and when required' (PRN) medicines, appropriate guidance was in place for staff to follow. This helps to ensure these medicines are administered in a safe and consistent manner.

At the last inspection we saw the topical medication administration records [TMAR] used to record when topical medicines such as creams, ointments and lotions were applied were inconsistently completed. On this inspection we again found TMARs were not always completed consistently and body maps to highlight where staff were to apply creams were not always completed. The manager told us this had been identified through an external audit and they were aware this was an on-going concern. Consistent and correct application of creams is important as it protects peoples skin and can be used to protect fragile skin from damage.

We saw evidence regular internal medicines audits were completed but they had not identified the issues raised at this inspection. This further evidences the system of governance was not sufficiently robust. This demonstrates a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a staff member dispensing people's medicines. They did this with kindness, explaining what the medicines were for as well as checking the person had taken the medicine before they left them. Senior staff responsible for administering medicines had recently completed a competency assessment and to ensure people received their medicines as prescribed. This showed us medicines were administered by staff with the knowledge and skills to administer medicines.

We found the home to be clean and generally odour free. One person told us, "My room is clean and how I want it." A relative said, "[Person's] room is clean and tidy." We saw personal protective equipment, such as gloves and aprons were available and we saw staff using them during the course of the inspection.

When things go wrong, it is important to reflect and review where improvements can be made in the future. We saw evidence of this from the manager's audits and action plans of falls and pressure ulcer management. The manager told us learning was shared with staff at meetings and through supervision. This demonstrated an open culture and shoed the manager was taking action to improve areas of identified weakness.

People told us they felt safe. One person said, "Yes I am safe here. I would not be here if I did not feel safe." Relatives also told us they felt their family member was safe. One relative said, "We have no problem with safety for our relative. We feel very comfortable with our relative staying here." Another relative said, "[Person] is safe and well cared for."

When we asked staff about safeguarding they were aware of the types of abuse and they understood how

and who to report any concerns they may have. The manager was also clear about their responsibilities in keeping people safe from the risk of harm or abuse. They told us they attended role specific safeguarding training provided by the local authority. We saw the procedure for staff to follow in the event of a safeguarding concern was on display in the reception area.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection we rated this key question as 'Requires Improvement'; we identified a breach in regulation as people's nutrition and hydration needs had not been met. This remained a concern at this inspection.

People were mainly complimentary about the meals, "The food is very good, I do enjoy it", "The food is very good. I get what I enjoy and want. I have plenty drinks given to me throughout the day" and "I like cornflakes. Some days I do not like sandwiches for lunch, the staff do give me something else that I like - there is plenty of drinks given. I can also have lemonade that I enjoy. The tea trolley comes twice a day as well." One person said, "The food sometimes is not very good, they do offer me something else which I like. I can have what I want and I have drinks all day as well." None of the relatives we spoke with raised any concerns regarding the meals at Willow Bank.

On the residential unit tables were set with the relevant cutlery. At breakfast time people were offered a choice of toast, tea, juice, cereal and full English breakfast. We observed service users coming at different times and we were informed that breakfast could be eaten whenever people got up. Most people ate their breakfast independently, we saw three people who were provided with appropriate support by staff. At lunchtime there were sufficient staff to ensure everyone received their meal promptly, people received support when it was needed.

On Elizabeth Wing staff prompted people to choose if they wanted to eat in the dining room and which seat they would like to sit in. In the majority of instances, staff asked people what they would like to eat and drink. For example, on the first day we heard people being asked if they wanted jam adding to their milk pudding, although no other choice of pudding was offered. On the second day of the inspection people were served sponge and custard, the pudding was pre-plated, therefore people were unable to decide if they wanted custard or not. Staff asked people if they had eaten sufficient amounts before removing their plates and drinks were offered at regular intervals. Where people required a soft diet, for example, due to a risk of choking, staff served them a meal with a soft or pureed consistency.

We reviewed six people's eating and drinking care plans, they were detailed and person centred. For example, one care plan noted 'likes to start the day with porridge and sugar flowed by slice of toast'. A malnutrition universal screening tool (MUST) had been completed. This is an objective screening tool used to identify adults who are at risk of being malnourished. People were weighed, although this was not always within the time frame specified in their care plan. For example, we saw no weight recorded for one person in May. The care plan for another person, dated 2 May 2018 recorded 'weekly weight' but their most recent weigh record was dated 'April 2018'. Where there were concerns regarding weight loss we saw evidence people's GP had been informed. The manager also showed us an audit they had recently implemented to ensure they had oversight of people's monthly weights.

One person did not receive appropriate support from staff. At 10.50am staff served the person a cup of tea and a slice of toast cut in half. Shortly after the person dropped a half slice of toast on the floor, at 11.55 a

member of staff removed the remaining toast and threw it away. We saw the person attempt their drink but when they had drunk about half of the drink they did not appear to have the energy required to suck the drink up the straw. Although we noted staff verbally prompted them to eat and drink, no one sat with the person to provide them with the support they clearly needed. We informed the registered manager of our observations at the end of the first day of the inspection.

At our previous inspection we noted a person who had been prescribed dietary supplements had not received these for two days as the stock had run out. This remained a concern at this inspection. One person was prescribed two supplements prescribed, one supplement had not been given for six days and the other for three days. This was because staff had failed to re-order the product in sufficient time.

These examples evidenced a failure to ensure peoples nutritional and hydration needs were being being met. This demonstrate a continuous breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager recognised the importance of ensuring people's care and support was delivered in line with current good practice guidelines. This was evidenced through the involvement of external health care professionals. They told us good practice was shared at staff meetings and supervision.

Two of the relatives we spoke with told us staff had the appropriate knowledge and skills. One relative said, "Staff are very good, they know what they are doing." Another relative said, "The staff are well trained and do care for our relative well."

The staff we spoke with told us they received a comprehensive induction which had included shadowing more experienced colleagues, until they were deemed competent and felt confident to work unsupervised. One recently appointed member of staff said, "Having never worked in care before I was a little nervous at first but I need not have worried the other staff were great. I shadowed a colleague for over a week and the manager made it clear I would not be asked to work unsupervised until I felt ready to do so."

The manager told us all new staff employed with no previous experience in the caring professional would complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. At the time of the inspection no new staff had yet been enrolled on the Care Certificate. Following the inspection, the manager told us two staff had begun to work towards achieving this qualification, supported by the clinical lead.

We saw some staff had been transferred to Willow Bank from the two other homes operated by the registered provider. The manager told us in these circumstances staff shadowed an experienced staff member for one day before being allowed to work unsupervised. The manager confirmed that all three homes operated by the registered provider worked to the same policies and procedures and therefore a full induction to the service was not necessary.

The manager told us some gaps in the training matrix had been identified through the internal audit system as a result of the in-house trainer leaving the organisation. However, they confirmed they were actively recruiting for a new trainer and in the interim a trainer from another service operated by the same provider and the quality manager were providing ongoing support to the staff team. We saw a number of training dates had already been arranged to begin to address this.

We saw individual staff training and personal development needs were identified during their formal one to one supervision meetings with the manager. In addition, staff also had practical supervision sessions based

on the needs of individual people living at the home and each staff member had an annual appraisal which looked at their performance over the year.

When we spoke with the district nurses they were concerned that there were not always clear lines of communication within the home which meant care staff were not always aware of changes in people's care and treatment. They confirmed they were working with the manager and senior management team to establish a stronger working relationship and as part of this process had regular meetings with them, including agreeing to facilitate a training session on pressure area care.

The district nurses said they were holding a weekly 'review clinic' where a range of care needs were reviewed as well as their twice daily visits to the home to support people who required regular nursing intervention. We also saw evidence in people's care files of the input of other healthcare professionals including; GP's, speech and language therapists, podiatrists and opticians. This demonstrated people received additional support to meet their healthcare needs.

We asked one of the staff we spoke with how information was shared within the staff team. They told us staff attended a daily handover when they came on duty they said the handover was verbal but a written record was retained.

Willow Bank is a purpose-built property with bedrooms to both the ground and first floors. There were a number of communal areas for people to use. There was signage on communal bathroom doors to help people identify their location. On Elizabeth Wing some of the walls had murals on them, these can add colour and interest to the environment. Both the residential unit and Elizabeth wing had access to a garden.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. The manager told us there was only one person living at the home with a DoLS in place, there were no conditions attached to the authorisation. A number of other applications had been submitted to the local authority and were awaiting review.

Care plans contained a range of decision specific capacity assessments and evidence of best interest's decision making. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005. We noted a DoLS had been applied for two people whose care files we reviewed but there was no evidence a capacity assessment had been completed in regard to this decision. This meant the full requirements of the MCA had not been met.

One of the files we reviewed evidenced the person's relative had a Lasting Power of Attorney (LPA) in place. An LPA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help make decisions or to make decisions on their behalf. This meant the manager had assured themselves of who could consent on behalf of a person living there and what decisions this related to.

Requires Improvement

Is the service caring?

Our findings

People told us staff were caring and kind. People said; "They are wonderful. The staff are caring, they respect me, they give me respect and dignity", "The staff are very good, caring, respectful to me. I do feel very comfortable with them" and "Staff knock on door before entering. They always ask my permission, they are very polite to me. They treat my room as my home, they respect what I want."

Relatives were also positive about staff. One relative said, "My relative is dressed well. We know the staff members, they give us and my relative respect." Another relative commented, "They (staff) look after our relative well."

One of the staff we spoke with said, "We would treat people the same as our parents at home."

Our previous inspection identified a breach of regulation as people were not always treated with dignity and respect. This remained a concern at this inspection. For example, we saw staff transfer a person in a hoist, the person wore a skirt which was half way up their thigh while being transferred, they were also bare legged. We observed a staff member move two people in wheelchairs, from behind. They did this without speaking to them to gain consent or explaining what they were doing.

We heard a member of staff giving verbal instruction to other staff in a loud voice in a communal area. We also heard a member of staff say loudly, "Come on [name of person], let's go the bathroom." The staff member then walked away, when they returned a few moments later the person had begun to walk into the lounge. The staff member said loudly, "Come on, come to the toilet."

Peoples personal property was not always treated with respect. On the first day of our inspection we found a bathroom cupboard on Elizabeth Wing was crammed full of various items including clothing and a lady's handbag. We checked the cupboard again later in the day and found the items had not been removed. We brought this to the attention of the manager, we checked the cupboard on the second day of the inspection and found all the items had been removed.

These examples demonstrate a continuous breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw many examples of kind, caring interactions. Staff spoke with the majority of people by name and smiled at people, banter between staff and people was friendly and professional. We saw a member of staff speaking calmly with a person who was distressed, holding their hand, the person asked the staff member to wipe their hands, which they did. Another staff member placed a cushion behind someone's back to make them more comfortable.

Where people had limited cognitive and verbal ability we did not see alternative methods used to aid communication. We asked staff how they supported people to choose their meals if they struggled to make a verbal choice. One of the staff showed us some laminated pictures of meals. We did not see these, or any

other methods being used by staff on either day of the inspection.

Staff knocked on people's doors before entering into their room. We saw staff knock and then enter a person's bedroom saying, "Good morning [name of person] how are you this morning?" When personal care was being given, the staff made sure that the doors to people's rooms remained closed to ensure privacy and dignity was maintained.

We saw the service had designated three staff members to be dignity champions and they carried out regular checks to ensure staff respected people's dignity by ensuring their personal care needs had been met in line with their preferences. However, as we have evidenced, this had not yet been effective in ensuring all people were consistently treated with dignity and respect.

People told us staff encouraged them to maintain their independence. One person said, "The staff are good, I am very independent, they respect me for this, they don't force themselves upon me." Another person said, "When I came here I could not talk, walk and was chair bound. It was the staff that encouraged me. I now can walk, talk and do what I want. I am where I am due to their encouragement."

Staff told us they encouraged people to be as independent as they could be. For example, they described how they helped people to choose what they were going to wear, by opening their wardrobe and showing them options.

We were not able to evidence people or their families had been involved in their care plans. For example, one care file contained a letter to the relative of the person asking them about their preferred level of involvement in their family members care plan. The sections to indicate their choice had not been completed. We asked a relative if they were aware of, or if they had been involved in their family member's care plan. They said they were not aware of the care plan.

Information was not always stored confidentially. For example, on the Elizabeth Wing a variety of folders, including food and fluid records were left on a table in the lounge area on both days of the inspection. On the Elizabeth Wing, care plans were stored in a moveable, locked cabinet. The cabinet was seen unlocked and unattended in the lounge.
A failure to ensure records and personal information is stored securely demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service responsive?

Our findings

Our previous inspection identified a breach of regulation as people's care and treatment was not appropriate and did not meet their needs or reflect their preferences. This remained a concern at this inspection.

The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. Care files included a communication care plan. Two people's care plans recorded they needed to wear glasses, neither person was seen to be wearing them. The care plan for another person recorded they required a hearing aid in both ears. They were not wearing them. We asked a member of staff, they said the night staff had reported the hearing aids to be missing that morning. A short time later the staff member told us the hearing aids had been located and the person was now wearing them.

The registered manager was unaware of the requirements of the Accessible Information Standard. We recommend that the registered provider takes steps to ensure they understand and meet this standard.

The manager told us either they or a senior staff member visited people prior to their admission to Willow Bank, to complete an initial assessment of their support needs, and gain an understanding of their background, likes and dislikes. They also told us if appropriate they actively encouraged people who were considering using the service and their relatives to have a look around the home and speak with staff and people already living there.

The care plans and supporting documentation we looked at were person centred. However, we found care plans were not always updated following changes to people's care and support, instead staff recorded information in the monthly review section of the care plan and did not always update the actual care plan. This meant staff may not be aware of current people's current needs and people may not be receiving appropriate care and treatment.

Records were not always accurate. For example, one person's record noted they had sore skin. A member of staff told us about the action taken by staff and assured us the sore area was now healed. This information had not been recorded. Another care file contained a body map. The document was undated and contained an entry 'bottom slightly sore'. We were not able to see if action had been taken or if the matter had been resolved.

Recording information was not always consistent. When staff supported people to change their position in bed staff recoded this on a reposition chart. Some staff were recording this information on the 'two hourly checks' chart instead of the repositioning chart which meant it was not always easy to establish if the person was receiving appropriate care and support.

Records did not evidence staff were repositioning people in line with their care plan. Staff meeting minutes

dated 14 March and 5 June 2018 evidenced the manager had discussed this with staff. The manager said they were now completing daily checks of the repositioning charts so that any failings could be identified quickly and addressed with individual staff members through supervision and training. We looked at the daily checks completed by the manager for the 29 May 2018, of the seven charts checked five showed people had not been repositioned in line with their agreed care plan. This demonstrated the actions taken by the manager had not yet been effective in ensuring this aspect of peoples care and support was being met.

There were discrepancies in the quality of people's food and fluid records. For example, one staff member told us a person had eaten all their main course but had declined a pudding. When we checked their eating and drinking record a staff member had recorded the person had eaten both courses. The daily record for another person recorded 'came back from hospital… plenty of fluids given'. When we checked their fluid record for that day, a total of 510mls was recorded, this conflicted with the entry made in their daily record. Staff had also failed to record the drink and toast we had seen people being provided with during the morning. We saw concerns about staff not completing and checking records was discussed at a general staff meeting held on the 5 June 2018.

These examples demonstrate a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as accurate and contemporaneous record were not always maintained.

We asked people how they spent their time; "I love painting, you can see in my room I have my paints. I do not do the activities downstairs as I enjoy painting in my room. I also do word searches and staff also bring me things for me to do. I like going outside but there is not much to do in the garden, there are no flowers, but fresh air is nice", "I enjoy watching TV, reading, I go to bingo twice a week- there is loads to do" and "As you can see my room is full of books. They respect me and allow me to do my painting and reading. The staff take the books I have read to a library they have made down in the library room, they also give me books to read."

The Activity Coordinator was highly visible and active around the service. They engaged with individual people as well as small groups. They were clearly highly motivated and enthusiastic about their role. A notice board displayed many photographs of people engaging in various activities at the home.

People told us they had no complaints but were aware of who to speak with if they were unhappy with the service they received.

We saw the service had a complaints procedure which was available to people who used the service and their relatives. We looked at the complaints register and saw five formal complaints had been received since our last inspection in January 2018 all of which had been investigated by the manager and an outcome recorded. The manager told us complaints were welcomed as they were used as a learning tool to improve service delivery.

However, although the manager told us they were pro-active in making sure low-level complaints and concerns were dealt with before they escalated to a formal complaint, these were not recorded. This meant it was difficult to establish the number and nature of the low-level concerns being received by the service and how they were being dealt with. This was discussed with the manager who confirmed they would address this matter and monitor the outcome through the internal quality assurance monitoring systems in place.

At our previous inspection we found people had not been supported to plan for their end of life care. At this

inspection we reviewed three end of life care plans. They recorded information about people's preferred undertaker and preference in regard to a burial or cremation. No other details were recorded, for example, where they wished to be cared for or their views on care and treatment. Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live well and die well in the place and the manner of their choosing.

We saw the manager had implemented a 'lessons learned audit' following a death at the home. We saw comments were made regarding what had gone well, but no areas for improvement had been identified.

Requires Improvement

Is the service well-led?

Our findings

We asked people and their relatives for feedback about the home's management team. Comments included; "I don't really have much to do with management", "The management are good, they ask me if I am happy", and "The management are brilliant, they have helped me so much. They are approachable." Two people told us they did not have much to do with the home's management team. While two of the relatives we spoke with said, "We see reception but not really the managers. Staff we do speak to all the time. They could do with management presence being a bit more" and "We have an excellent relationship with management."

The registered provider is required to have a registered manager as a condition of their registration. At the time of inspection, the new manager had been in post for approximately five months and was in the process of applying for registration with CQC.

Our previous inspection identified a breach of regulation as systems of governance were ineffective. The manager told us since taking up post in January 2018 they had made a number of changes to improve service delivery but acknowledged this was still very much work in progress.

We saw there was an audit plan in place which outlined when specific audits were to be carried out throughout the year. We saw the quality manager employed by the organisation carried out three monthly compliance audits which covered all aspects of service delivery and external consultants also carried out a six-monthly compliance audit. One of the company directors also monitored the quality assurance process to ensure the audits carried out were effective and identified any shortfalls in the service.

We found internal audits had not always been completed within the specified timeframes. For example, health and safety and environmental audits were to be completed on three-monthly basis. We saw a cleaning audit had not been completed since January 2018 and a bed rail audit had not been completed since June 2017. We brought this to the attention of the manager, following the inspection they emailed us to confirm a bed rail audit had now been completed.

The manager told us they had an action plan which they emailed to us after the inspection. However, this simply detailed the auditing schedule. It did not detail what issues were to be addressed, how, when or by whom.

Since the last inspection we saw some improvements had been made, for example, staff recruitment, the management of people's skin integrity, improving relationships with the district nursing team and the implementation of dignity champions. However, regulatory breaches
identified at our previous inspection had not been fully addressed. As we have clearly evidenced throughout this report people were still not receiving a consistently safe, effective, responsive or caring service. We have identified weaknesses in the management of fire safety, the storage of medicines, people's nutrition and hydration needs were still not being met and staff were not always treating people with dignity and respect. Despite the high level of concerns regarding people's skin integrity staff were still failing to ensure records

were accurate and evidenced actions taken to address identified concerns.

These findings evidence the systems of governance are still not sufficiently robust and therefore demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the manager told us they had implemented a daily management meeting. They met briefly, each daily with the senior staff on duty to improve communication, share information and provide support and guidance.

We saw evidence the manager was beginning to work in partnership with other organisations, for example, the district nursing team to improve the quality of the provided.

One person who lived at the home told us, "I have given my opinion through interval questionnaires." The manager told us as part of the quality assurance monitoring process they sent out annual survey questionnaires. The most recent survey had taken place in July 2017. The information provided had been collated and an action plan formulated to address any concerns raised. This was clearly displayed within the home.

A relative told us meetings were held every three months and the manager told us they held regular meetings with people who lived at the home and their relatives [Friends of Willow Bank]. We saw minutes from meetings held in March and April 2018. Topics discussed included the findings from the previous CQC inspection and the action being taken by the registered provider to address the concerns identified.

We asked staff about the management of the service. They all told us the manager and deputy manager were very approachable and had an open door policy. They also told us that staff morale and team work had improved since the last inspection. We saw that staff meetings were held on a regular basis so that people were kept informed of any changes to work practices. We saw evidence to show the last inspection report had been discussed with staff at all levels of the organisation to drive improvement. In addition, an annual staff survey was carried out to seek their views and opinions of the service and to establish the level of engagement they have with the home and organisation.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not consistently treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not being met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes of governance were not effective. There had been a failure to robustly assess, monitor and improve the quality and safety of the services provided. There had been a failure to robustly assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who use the service. Record were not always stored securely and were not always an accurate, complete and contemporaneous record.