Thurlestone Court Limited

Willow House

Inspection report

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Date of inspection visit:
07 February 2017
10 February 2017

Date of publication:
19 June 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Willow House is a care home registered to provide personal care and accommodation for up to 30 older people. The majority of people who lived in Willow House were living with a form of dementia.

We carried out a previous inspection of this service on 10 May 2016 where we identified breaches of regulation. We found improvements were required in relation to the management of medicines, in relation to following specialist guidance, records management and the quality assurance systems. At this inspection on 7 and 10 February 2017, we found some action had been taken to respond to our concerns in relation to medicine management, but found action was still required to further improve this, and we identified other areas of concern.

This inspection took place on 7 and 10 February 2017 and the first day was unannounced. At the time of our inspection there were 20 people living in Willow House. People had a range of needs, with most people at the home living with a form of dementia.

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The timing of this inspection was brought forward following a number of safeguarding concerns as well as information of concern being received. These concerns related to people not being cared for safely, one person having their call bell taken away by staff, people's individual needs not being responded to and people not being treated with respect. We found evidence of most of these concerns during our inspection but did not find any evidence of staff failing to treat people with respect.

Since May 2015 Willow House has been inspected four times and at each of these inspections we found breaches of regulation and the service was rated requires improvement. Although the provider was working hard to improve systems and practices at Willow House, concerns relating to people not always receiving safe care and treatment and quality assurance processes being ineffective at identifying concerns persisted. We found the systems in place to monitor the quality and safety of people's care were not effective and had not identified significant issues.

People who lived in Willow House were not always safe. Sufficient action had not always been taken to protect people from the risks of harm. Risks to people had not always been identified and risk assessments were sometimes not completed, or did not provide any guidance on how staff were to minimise or manage risks. This included risks relating to falls, weight loss, seizures, suicidal thoughts, aggressive behaviours and people's behaviours which could pose risks to themselves.

The registered manager, senior management and staff did not have a good understanding of the Mental

Capacity Act 2005 (MCA). Where one person who had capacity to make decisions, had expressed their wish for bed rails not to be used on their bed. We found that bed rails were regularly being used on their bed. There was no evidence this person's consent had been sought and recorded when these had been used.

People did not always receive care which was person centred and reflected their individual needs. People's care plans did not always contain sufficient detailed information for staff to meet people's needs. In one instance, a person did not have a completed care plan after having been living in the home for a period of almost seven weeks. This person had specific needs relating to their personal care and staff had not been instructed on how to meet these needs. Records showed this person's needs had not been met in the way they required on a number of occasions.

The systems in place for assessing and monitoring the quality and safety of the care at the home had not been effective in identifying the issues we found during the inspection. The quality assurance systems did not look at people's care or risk management and simply checked records and charts for potential gaps. Although charts had been checked, concerns identified within these had not been picked up for. For example, food charts were being checked weekly but had not identified that one person was eating a pureed lunch and snacks which consisted of biscuits, sandwiches and pasties. This issue had not been looked at and therefore it had not been identified that no specialist guidance had been sought for this person in a number of years and that original guidance which had been shared by word of mouth was not being followed either.

People, relatives and staff spoke highly of the registered manager and told us they provided visible, approachable leadership. Staff told us the registered manager picked up on poor practice and led by example.

Although improvements had been made in relation to records and these were regularly checked as part of the auditing system, we found records for people were not always accurate or up to date.

Recruitment procedures were in place to ensure people of good character were employed by the home. Staff underwent Disclosure and Barring Service (police record) checks before they started work in order to ensure they were suitable to work with people who were vulnerable. Staffing numbers at Willow House were sufficient to meet people's needs and provide them with individual support.

Staff treated people with kindness and respect. Although prior to our inspection we had received information of concern relating to the culture in the home and the demeanour of staff, during our inspection we saw positive and caring interactions between people and staff. We found staff had caring attitudes towards people and provided people with affection and humour. Staff knew people's needs, preferences, likes and dislikes and spoke about people with respect and admiration.

People were supported to make choices about what they wanted to eat and food was presented in ways which met people's individual needs. People told us they enjoyed the food.

In light of some of the significant concerns we identified relating to people's safety, we made alerts to the local safeguarding team. Since the inspection the local safeguarding team and the local authority have been working with the provider.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not always being protected from harm, people's rights being restricted, staff not following the principles of the MCA, people's care not always meeting their needs, ineffective

quality assurances processes and people's records not always being accurate or up to date.

We are considering our actions in line with CQC's enforcement policy. We will publish a further report that details what action we have taken at a future date . Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

People were not always protected from risks relating to their safety and wellbeing as these had not always been identified or acted on.

Where accidents and incidents had occurred, actions were not always taken to ensure these did not happen again.

Specialist guidance was not always being sought or followed in relation to risks to people.

Some medicine management processes were not safe.

People were protected from the risk of abuse as staff understood the signs of abuse and how to report concerns.

People were supported by sufficient numbers of staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not effective.

Decisions were made for some people without either their consent or best interests decisions taking place, because of a lack of understanding of the Mental Capacity Act 2005.

People enjoyed the food.

Staff received regular supervision and a yearly appraisal.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the caring attitude of staff.

People were treated with dignity and respect.

Staff supported people at their own pace and in an individualised way.

Staff knew people, their preferences and histories well.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive care which met their individual needs.

People's care plans and risk assessments did not provide staff with sufficient information to meet people's needs.

People benefited from activities which reflected their preferences.

People were encouraged to make complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The systems the provider had in place to assess and monitor the quality and safety of care had not identified the concerns we found during our inspection.

People's records did not contain up to date and accurate information.

Staff, people and relatives spoke highly of the registered manager.

The provider sought feedback from people, relatives and staff.

Willow House

Detailed findings

Background to this inspection

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

This inspection took place on 7 and 10 February 2017 and the first day was unannounced. One adult social care inspector and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. On this inspection the expert by experience had experience of supporting a person living with dementia.

During the inspection we spoke with 13 people who lived in Willow House. We also spoke with three relatives, seven members of staff, two visiting healthcare professionals, the registered manager, two senior managers and one of the directors.

During this inspection we did not conduct a short observational framework for inspection (SOFI) as a number of people were able to share their experiences with us. SOFI is a specific way of observing care to help us understand the experience of people who are unable to talk to us. We did, however, use the principles of SOFI when carrying out observations in the service.

Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us. During the inspection we looked at the way people were being supported, looked at the way in which medicines were recorded, stored and administered, and looked at the way in which meals were prepared and served. We looked in detail at the care provided to five people, including looking at their care files and other records. We looked at the recruitment and training files for three members of staff and other records relating to the operation of the home such as risk assessments, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Following our previous inspection in May 2016 this domain had been rated as Requires Improvement. This is because we had identified concerns relating to the management of medicines. At this inspection in February 2017 we found action had been taken to improve the management of medicines. We did, however, identify one concern relating to the management of medicines and a number of other concerns relating to risks to people not being identified or managed safely.

During our inspection we found people who lived in Willow House were not always safe. Although we found examples of risks being identified and action being taken to respond to these and minimise risks, we found this was not always the case and people had potentially been unsafe whilst at the home. We found concerns relating to risks to people not being identified, management plans not being put in place to minimise risks and specialist guidance not always being sought or followed in relation to risks to people.

Risks to people's health and wellbeing were not always identified or acted on. For example, one person had lost 2.7kg in weight in the month prior to our inspection. This person had previously experienced a period of weight loss and actions had been put in place to respond to this risk. This had resulted in the person gaining weight. Once the person had gained weight the actions put in place to minimise their risk of malnutrition had been discontinued. The recent weight loss experienced by this person had been recorded but when asked, neither staff or the registered manager were aware the person had lost weight. This person's recent weight loss had not been identified as a risk. This person was not having their food intake monitored, had not been referred to a specialist or their GP; their diet had not been changed and staff had not been instructed to encourage the person to eat more. These actions had previously been successful in protecting this person from the risk of malnutrition. We raised our concerns to the registered manager about the risks to this person. On our second day of inspection the registered manager told us the person had been placed on a food and fluid chart in order to monitor their eating and drinking. They also told us this person had been referred to their GP for further advice.

Where risks had been identified, action was not always taken to minimise the risks. For example, one person had been recorded as having a history of falls on their admission to Willow House. Their falls risk assessment indicated they were at high risk of falls but this had not been updated since March 2016. Since that date this person had suffered seven falls. There were no actions taken to minimise the risks to this person relating to falls. The action plan section of their risk assessment only contained information about this person having a history of falls, no information about what actions had, could or were being taken. The registered manager told us they did not think the number of falls this person had experienced met the criteria for referring them to the specialist falls team and had not considered other options available to minimise any risks. One member of staff told us that "a while ago", prior to our inspection, the person had been observed to climb over their bed rails and therefore those had been removed. They did not know of any other control measures having been implemented in order to minimise the person's risk of falling.

Another person experienced periods of heightened anxiety and had been observed to go into other people's rooms without permission. On one occasion, when this person was in someone else's room, they became

aggressive and caused significant damage to the room. Neither staff, management or the quality assurance systems had identified the potential risks these behaviours could pose to this person or to others. Specialist guidance had not been sought, a risk assessment had not been completed and staff had not been provided with any guidance on how to manage these behaviours.

A third person displayed behaviours which caused them to ring their call bell repeatedly through the night. This person was also at high risk of falls as they regularly attempted to mobilise independently. Prior to our inspection an incident had occurred whereby night staff had removed this person's call bell intentionally as the person was ringing it so often. Staff and the registered manager spoke openly about the regularity of the ringing and how this caused them frustration. The registered manager had not identified that these behaviours could pose risks to this person as staff could become more complacent to the regular calls and therefore not respond urgently in the case of a real emergency. No risk assessment of action plan had been created to minimise any risks these behaviours could potentially pose to this person.

Following the first day of our inspection we discussed our concerns detailed above with the registered manager and two senior managers. When we inspected on the second day we found action had been taken to respond to the concerns we had raised. Referrals had been made, the GP had been contacted and risk assessments had been created. We had asked the registered manager and senior managers to review the risks to the person who repeatedly rang their bell. They had reviewed this, but had not reviewed how this person was also at risk because of having seizures. This person had experienced a number of seizures in November 2016 which had required hospitalisation. On our return to the home no risk assessment or action plan had been created in relation to this. Staff did not have any guidance on how the person presented when they experienced seizures or what actions to take to protect them should they occur. Staff confirmed they did not know how they would recognise if this person was experiencing seizures. Although this person's care plan and risk assessments had been reviewed by the registered manager and a senior manager following the first day of our inspection, no plans or guidance had been put in place in relation to minimising risks relating to their seizures.

Where specialist guidance had been sought and provided, this was not always followed. The registered manager told us one person was receiving a soft diet following an assessment completed by the speech and language therapists (SALT). The registered manager told us this assessment had been completed prior to them becoming manager and they had never seen a copy of this assessment or guidance. During our inspection the registered manager attempted to locate this guidance but was not able to. They told us the guidance dated back more than three years. The registered manager had not requested a copy of the guidance from SALT prior to our inspection and had not requested a review in order to be certain they were protecting this person from potential risks relating to choking. Although we were told this person was on a soft diet, we saw the person was having both a pureed diet and biscuits, sandwiches and pasties. This demonstrated this person was not receiving a soft diet and this was a potential risk to this person.

During our inspection the registered manager was administering people's medicines. On one occasion we observed them come into the living room carrying two dispensing pots containing medicines for two separate people. We asked them about this and they explained they could easily tell the difference between both people's medicines because one pot contained a very large pill only one person took. They acknowledged they should not be carrying two people's medicines in pots at the same time as this could lead to potential error and told us they did not do this regularly and would ensure staff did not copy this practice.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The majority of the people who lived in the home required support from staff to take their medicines. Staff told us they were confident people received their medicines as prescribed by their doctor. Records showed, and staff told us they had been trained to administer medicines safely and had their competencies checked. Staff administering medicines carried out daily medicine checks to ensure people had received their medicines and any errors were picked up without delay. Weekly medicine audits were also completed by a senior manager.

There were sufficient staff available to meet people's needs. During the day there were four members of care staff, a cook, a kitchen assistant and the registered manager. A member of domestic staff worked three days a week. During the night there were two members of waking night staff working. During our inspection we observed staff responding to call bells quickly and saw people's needs were met in an unhurried manner. People had mixed views about staffing levels with some being happy with the numbers and the ability of staff to meet their needs and others telling us things could be improved. One relative told us "It's okay weekends, but there is no manager on weekends and it does feel a bit sparse". One person said about the staffing, "Sometimes a bit short, but we are still well looked after".

Recruitment practices ensured, as far as possible, that only suitable staff were employed at the home. Staff files showed the relevant checks had been completed to ensure staff employed were suitable to work with people who are vulnerable. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained as well as full employment histories; this protected people from the risks associated with employing unsuitable staff.

People at Willow House were protected by staff who knew how to recognise signs of possible abuse. Staff and records confirmed they had received training in how to recognise harm or abuse and staff told us they knew where to access information should they need it. Safeguarding information and relevant contact numbers were displayed in the registered manager's office for staff to use. The registered manager told us safeguarding was regularly discussed with staff during staff meetings.

There were arrangements in place to deal with foreseeable emergencies and each person had a personal emergency evacuation plan in place. This detailed how people needed to be supported in the event of an emergency evacuation from the home. The premises and equipment were well maintained to ensure people were kept safe. Regular checks were undertaken in relation to the environment and the maintenance and safety of equipment. Good infection control practices were in use and there were specific infection control measures used in the kitchen, the laundry room and in the delivery of people's food and personal care.

Requires Improvement

Is the service effective?

Our findings

During this inspection we identified some concerns relating to a lack of understanding on behalf of the staff, the registered manager and a senior manager in relation to the Mental Capacity Act 2005. This had resulted in people potentially having their rights restricted.

Most of the people who lived in Willow House were living with a form of dementia. These conditions may have affected their ability to make specific decisions at specific times. We therefore checked whether Willow House was working within the principles of the Mental Capacity Act (2005) The 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. We checked whether the service was working within the principles of the MCA.

We found a lack of understanding in relation to the MCA and the five statutory principles of the MCA on behalf of the registered manager, the senior managers and the staff. The five principles of the MCA include that all individuals are presumed to have capacity; an action taken on behalf of a person must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms. The registered manager was not always following these principles with regards to people who may lack capacity to make certain decisions.

Staff had been putting up bed rails on one person's bed without their expressed consent. One person who lived in Willow House had been assessed as having full capacity to make decisions about their care. This person was at risk of mobilising on their own, getting out of bed and falling. The risks had been explained to them by the registered manager but they had refused to have bed rails used on their bed. This person had highly complex needs and behaviours and the registered manager had sought advice and guidance from a local specialist health service. This advice, however, had not provided the registered manager or the staff with clear guidance on how to manage this person's behaviours relating to getting out of bed and falling in the night. The registered manager told us this person had been very clear and decisive in these views with regards to not wanting the bed rails in place. Daily records for this person in the weeks prior to our inspection, however, evidenced the staff using the bed rails on the person's bed during some nights. On occasion these had been put up following a fall and other times the recordings included very basic information, such as '[Name of person] already in bed with the cot sides up at 20.00'. There was no record of the person having been asked for their consent for the rails to be put up or how long they would be up for. There was no evidence to suggest this person did not have the capacity to make the decision about having their bed rails up on the occasions these had been used. The registered manager told us staff had told them the person had not refused the bed rails on the occasions they had been put up but that they had not specifically been asked for their consent prior to putting them up. This may have restricted this person's freedom of movement and placed them under unnecessary control.

Following the first day of our inspection, we asked the registered manager and the senior managers to

review the plans in place for this person in relation to the bed rails and obtain professional advice and guidance. The following day, 8 February 2017, the GP had come to the home and had completed a mental capacity assessment with this person in relation to the use of bed rails. This had been completed alongside the registered manager. The GP and registered manager had gone through the assessment with the person who again had declared they did not want bed rails to be used. The assessment found they had full capacity to make this decision. Although the assessment had shown they did not lack capacity, the GP had instructed 'In interest of her safety I feel it would be reasonable to use bed rails during periods of high anxiety.'

This guidance had been used by the registered manager and a senior manager to complete a bed rails risk assessment and staff had continued using them. Neither the registered manager or the senior manager had questioned the GP's guidance or asked some follow up questions. There was no evidence to suggest this person lacked capacity at times of 'high anxiety', what 'high anxiety' looked like for this person, how long this state lasted for, how staff should identify these times, how they should react and what actions they should take before resorting to actions which restricted their freedom of movement. During the early hours of the second day of our inspection, 10 February 2017, the person had experienced a fall. Records showed bed rails had been used following the fall. There was no evidence to suggest the person was experiencing 'high anxiety' during this period. This demonstrated a lack of understanding in relation to restricting people's rights and the use of the Mental Capacity Act 2005.

We did find examples where specific assessments had taken place for people in relation to a specific decision and a best interests decision had been made, however, this was not always the case. One person had been assessed as lacking capacity to make some decisions about their care. This person had been served lunchtime meals which were pureed in consistency. There was no evidence to explain why this action was taking place but the registered manager told us this decision had been made because of the person's lack of teeth. The person had not been consulted about this decision and no best interests discussion or decision had taken place. Daily food charts showed this person was eating a variety of foods which were not pureed, so there was no clear medical reason why their lunchtime meal was pureed. This had not been done because of the person's personal choices and was a restriction of their right to choose.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 any conditions on authorisations to deprive a person of their liberty were being met. Most people at the home were under constant supervision and were not able to leave the home unescorted in order to keep them safe. The registered manager had made the appropriate DoLS applications to the local authority. Some of these were still awaiting authorisation.

Staff had undertaken training in areas which included safeguarding adults, first aid, fire safety, moving and assisting, food safety, infection control and mental health and dementia. Staff told us they had received sufficient training to carry out their role and meet the needs of the people at the home. Staff training needs were regularly reviewed and the manager discussed these with staff. Staff said "We get good training" and "If I wanted more training I could have it."

Staff were encouraged to work towards further qualifications and all staff at the home were either working towards a diploma in care or the Care Certificate. This certificate is an identified set of standards that care

workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.

Staff told us they felt supported by the registered manager and had regular supervision and a yearly appraisal. During supervision and appraisal staff had the opportunity to sit down in a one to one session with their line manager and talk about their job role and discuss any issues they may have.

There was a full time cook at the home who catered to people's individual tastes and preferences. Most people chose what they wanted to eat from a daily menu and extra options were given to them where these choices did not meet their preferences. On the first day of our inspection the meal choices consisted of garlic chicken with mashed potato and a vegetarian option. We observed one person asking for a salad instead of the options on offer. The cook came to speak with the person and ask them what toppings they wanted for their salad. The person told us "I'm going to have a salad instead of chicken. It's very nice food." Some people spoke highly of the food at Willow House, with comments including "It's delicious, it really is" and "All I can say it's marvellous food they put out."

During our inspection we observed the breakfast and lunchtime meals. Most people's meals were presented in different ways to meet their preferences and their needs. People chose to eat in the dining room, the living room or their bedrooms depending on their preferences. People's meals looked appetizing and we observed people chatting amongst themselves during their meal. Throughout the day people were provided with a selection of hot drinks and snacks.

People were supported by staff to see healthcare professionals such as GPs, mental health practitioners, social workers, district nurses, chiropodists, occupational health practitioners, opticians and dentists. Although we identified some concerns with people not being referred to specialists where specific risks had been identified, we found numerous examples of professionals being contacted and involved in people's care. During our inspection we spoke with two healthcare professionals who were visiting the home. They told us they were called to the home appropriately and any advice they gave was listened to and followed.

Good

Is the service caring?

Our findings

Prior to our inspection we had received concerning information relating to the culture at the home and the behaviours of staff not demonstrating respect for people. These concerns had been shared with the provider and the registered manager who had taken actions to respond to these concerns and speak with staff. During our inspection we did not identify any concerns relating to people being disrespected.

People and their relatives spoke highly of the staff at Willow House. Comments from people included "The carers are absolutely brilliant", "All the girls here are so polite" and "They are very helpful, they are gorgeous. Nothing is too much trouble."

The registered manager told us they had taken a photograph of themselves and another member of staff with a person who lived in Willow House. The person had loved the photograph and so the registered manager had printed the picture and had it framed for the person. This person carried the framed picture around the house with them and referred to it saying "These are my two best friends." This demonstrated people felt close to the staff.

During our inspection we observed some pleasant interactions between people and staff. We saw and heard people chatting with staff, sharing jokes, terms of endearment and showing physical affection. The registered manager and staff made comments which demonstrated they cared for the people who lived in Willow House. Comments included "She's adorable" and "I love her I really do." Some staff talked to us about a person who lived in Willow House who had been playing the piano in the lounge. They all commented on how talented the person was and said "He's really good" and "He's incredible." This demonstrated staff valued people's individual skills and talents as well as their personalities.

People's privacy and dignity were respected. Staff knocked on people's bedroom doors and waited for a response before entering. Care was taken to protect people's modesty and privacy during any personal care. One person told us "They cover me up, and when I go to the shower they put towels around me."

People were encouraged to remain as independent as possible with regards to everyday skills. People's care plans highlighted what people were still able to do for themselves and how staff should support and encourage them to maintain these for as long as possible. For example, where some people were able to take part in their own personal care, staff were instructed on how to enable them by putting toothpaste on their toothbrush for them or passing them the flannel to wash their face.

People were involved in all aspects of their care and were asked for their opinions. Staff offered people choices in ways they could understand in order to ensure people were involved as much as possible. We saw staff asking people for their opinions throughout the inspection, from where they would like to sit, to what they would like to eat.

The environment was warm and welcoming, with people receiving visitors throughout the day. The communal areas were specious and light with ample room for people to move around. There were a

number of items, games and activities for people to pick up and interact with.

Requires Improvement

Is the service responsive?

Our findings

During this inspection we identified concerns relating to people's individual needs not always being met, professional advice not always being followed and people's care plans not always containing necessary information.

People who lived in Willow House had a variety of needs and required varying levels of care and support. People had needs relating to their physical health, their mental health, their dementia and their wellbeing.

We looked in detail at the care and support plans and other records for five people receiving care. The local authority had created a care plan for one person, but the service had not developed their own to meet the needs of this person whilst they were in the home. This person had moved into the home on 22 December 2016 and had therefore been living in Willow House for almost seven weeks by the time we conducted our inspection. The registered manager told us this person had come into the home on respite and had been planning on only staying a short while. The date of their leaving had kept being pushed back and therefore no care plan had yet been created. The local authority had prepared a care plan for this person which detailed the assistance they required in specific areas. This person had individual and significant needs relating to their personal care and their continence. The care plan from the local authority gave highly detailed information about these areas and the support required from staff in order to ensure this person maintained their dignity and did not experience heightened anxiety as this was a risk for them. This person's individual areas of need had not been highlighted to the staff. Records showed this person had not been assisted in the way they needed with their personal care on a number of occasions, with the most recent occasion being the weekend prior to our inspection. The registered manager told us they had placed the local authority care plan for this person within the staff handover book but had not checked to make sure staff had read it and were meeting this person's needs.

This person's local authority care plan made specific reference to the physical reasons for this person requiring support with their continence needs and stated that this person experienced high anxieties in this area. It was clear the person was not in control of this area of their life due to physical reasons. We had received concerns prior to our inspection in relation to this person's continence care needs and staff's lack of understanding and lack of respect for this person in this area. Records showed two daily note entries which demonstrated a lack of understanding and respect on behalf of the staff. We asked staff about this person's care and they did not demonstrate a clear understanding of their needs.

Another person had specific needs relating to their mental health and were very demanding on staff's time and attention. This person would ask staff to support them to use the toilet on a highly regular basis and would ring their call bell a large number of times during the night. Within this person's care plan we saw a letter from their psychiatrist. This letter stated 'There seems to be no evidence that a 'challenging or leadership' approach is effective.' We found, however, that this was the only approach being used by staff and the registered manager. This person's care plan also stated that when this person would get anxious it was 'essential to be firm' with them. This was not in keeping with the advice from the professional. During our inspection we observed the registered manager using a challenging and leadership approach when

speaking with this person about the regularity of their requests to use the toilet. The person's reaction was to become upset and verbally express concern about being "thrown out" of the home.

People's needs had not been fully explored or responded to. Although this person's care had been regularly reviewed by the registered manager and their charts had been regularly reviewed by a senior manager, potential risks or potential physical ailments had not been identified. Staff, the registered manager and senior management, had attributed all concerns to their behaviours. For example, although the person had been drinking large amount of fluids per day (up to 2700mls the week prior to our inspection), this had not been identified as potentially being the cause of their constant demands for the toilet or these demands potentially being the symptoms of a physical condition.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans we looked at contained detailed information about people's needs which demonstrated that time and thought had gone into making each plan personal and reflect people's specific needs and preferences. Where care plans did contain detailed information, these contained clear guidance for staff to follow as well as information that was important to people, such as their previous careers and their families. Staff were able to tell us about most people's specific needs and how they supported people. This, however, was not always the case.

People told us with enthusiasm about the activities they participated in. People's comments included "I read a lot, I have the Telegraph every day" and "I read, listen to music, word search." One person told us they enjoyed bird watching out of the large windows in the lounge as well as painting and drawing. The home had a minibus they shared with a sister home and people told us they had been out on trips. One person said "They have a van here and we went to Torquay. It was about a month ago. We walked around to soak up the air."

During our inspection we observed a number of activities taking place. An outside musical entertainer came in on the first day of our inspection. People enjoyed the show and made individual requests. On the second day of our inspection a fitness instructor came into the home and people enjoyed taking part in exercises which entertained them as well as bringing them health benefits. Staff spent time with people individually and in groups chatting and sharing jokes. At one point a member of staff created a word search game on a large white board and brought it round to people so they could participate. People got involved in this game and enjoyed it.

A complaints policy was in place at the home. People had access to the complaints procedure and were encouraged to make complaints should they wish to. The registered manager encouraged people and staff to share their views and concerns with them in order to enable them to take action without delay. People, relatives and staff told us they felt comfortable raising concerns with the registered manager and were confident they would listen and take action. Comments from people included "I would see the leader." Staff comments included "I would feel comfortable raising concerns, they would listen."

Inadequate

Is the service well-led?

Our findings

Since May 2015 Willow House has been inspected four times, three comprehensive inspections and one focussed inspection. At each of these inspections we found breaches of regulation and the service was rated requires improvement. At our comprehensive inspection dated 3 May 2015 we identified five breaches of regulation, including regulations 12 and 17. These relate to people not always receiving safe care and treatment and governance and quality assurance systems not being effective. At our focussed inspection dated 26 November 2015 we identified three breaches of regulation, including regulations 12 and 17. At our inspection dated 10 May 2016 we identified two breaches of regulations, these were regulations 12 and 17. At this inspection in February 2017 we again identified breaches in regulations 12 and 17 along with two further breaches.

Although the provider was working hard to improve systems and practices at Willow House, concerns relating to people not always receiving safe care and treatment and quality assurance processes being ineffective at identifying concerns persisted.

During this inspection, in February 2017, we found concerns relating to risks to people not always being identified or acted on. These risks related to the management of falls, weight loss, seizures, choking, behaviours. We also found concerns relating to consent not always being sought from people and specialist guidance not always being followed. Although action had been taken by the provider and registered manager to improve the quality assurance systems and records and they were responsive to our feedback, we still had concerns in these areas. We found the systems in place to monitor the quality and safety of people's care were not effective and had not identified significant issues.

The leadership at Willow House consisted of a registered manager, who had registered with the Care Quality Commission (CQC) in January 2016, and four shift leaders. Further management was provided by two directors, two senior managers, who undertook audits and quality assurance checks, and two human resources (HR) staff who provided management support.

The registered manager was in the process of completed their level five diploma in management for health and social care. Following our previous inspection in May 2016, they had been provided with some support to develop their skills. This included some learning sessions with senior managers and a consultant. The registered manager received three monthly supervisions. These were undertaken by a member of the HR staff and these meetings revolved around discussing staff and staff management issues. There was no system in place to enable the registered manager to formally discuss people's care, risk management or effective care planning. There was no process for them to identify potential gaps in their knowledge, any training requirements they may have or learn from potential mistakes or reflection on their practice. During the inspection we identified a number of concerns relating to the systems in place not identifying or acting on risks.

The systems and processes in place to monitor the safety and quality of care had not been effective in identifying the concerns we found during our inspection. Although regular checks and audits took place,

these did not include looking at people's care, risks or the content of risk assessments. Therefore, the registered manager was not aware of risks to people not being identified or acted on until our inspection. These risks included risks relating to falls, weight loss, seizures and aggression.

Regular checks undertaken by senior management focussed on reviewing records such as food and fluid charts, these were checked weekly and were reported on during a monthly report prepared by senior management. Although we found one person was eating a diet which was potentially either a risk to their safety or a risk to their rights being respected, this had not been identified during these checks. The monthly report for January 2017 stated 'There are no concerns regarding food and fluid intake and Willow House for this month.' This was not accurate and did not highlight the concerns we identified to enable the registered manager to take action. This example demonstrated the quality assurance systems and processes in place were not effective in identifying concerns relating to the care people were actually receiving or effective in identifying potential gaps in the registered manager's knowledge and potential training needs.

People's records were not always accurate and up to date and therefore the provider and registered manager were unable to assure themselves people were receiving the care they required. We found people's risk assessments and care plans did not contain up to date information about their care needs and risks. We found the home used a handover book where staff recorded any updates relating to people's care that needed to be passed onto the next shift. This book contained extremely basic information which did not contain sufficient or accurate detail in order to ensure staff knew important information about people's care. For example, one person had experienced a fall during the night. This fall potentially caused their ankle to be fractured in two places and caused their mobility needs to change over the next few days and weeks. The handover book for the morning following their fall stated in the morning 'Restless' in the afternoon 'No afternoon handover needed' and at night 'In bed.' There was no record of this person having suffered a fall or requiring different support with their mobility in the days to follow. The quality of the records for this person do not enable us or the provider to determine whether this fall did indeed cause the fractures or whether a later incident involving bed rails caused these.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to our inspection a number of complaints and a whistleblowing had been received raising concerns of staff being disrespectful towards people and a poor culture at Willow House. During our inspection we found no evidence of this. The provider had conducted an investigation and had taken steps which involved disciplining staff and raising a number of formal concerns with the registered manager. During our inspection we found the registered manager mainly led by example and staff told us their performance was monitored and the registered manager picked up on poor practice.

People and their relatives were encouraged to give feedback. Yearly questionnaires were sent to people who lived in Willow House and their relatives. Once these questionnaires were completed and returned, they were analysed and the registered manager told us action was taken to respond to any concerns raised. We did ask about one comment which had been made which stated 'Some staff are better than others'. The registered manager told us they had not conducted further investigations into this comment and whether any action needed to be taken. They told us this was due to them knowing the person who had made the comment and not believing it to be of concern.

People, relatives and staff spoke highly of the registered manager and told us they were approachable.

Comments included "I only have to ask to speak to her and she comes" and "If I've got anything on my mind I can talk to [Name of registered manager]. She's amazing, she's so approachable." Staff also told us the registered manager was supportive and listened to them. They told us they were encouraged to share ideas and these were listened to. For example, during a recent staff meeting, staff had been asked to share their views about the menu. Their suggestions and ideas had been shared with the cook and implemented.

'Resident meetings' also took place during which people were asked for their views and ideas. During a recent meeting people had expressed the wish for more activities in the home. The registered manager had asked people for their ideas and was looking into implementing these.

As far as we are aware, the provider met their statutory requirements to inform the relevant authorities of notifiable incidents.

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 9 HSCA RA Regulations 2014 Person-centred care People's care did not always meet their needs or reflect their preferences Regulation 9 (1)(a)(b)(2)(3)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health and safety had not been identified or mitigated. Regulation 12(1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems and processes in place to assess, monitor and mitigate risks to people. Regulation 17 (1)(2)(a)(b)(c)