My the Orchards Ltd

Willow Tree House

Inspection report

3 Sutton Road
Mansfield
Nottinghamshire
NG18 5ET

Tel: 01623471300

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19 January 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Willow Tree House is a care home providing personal care for up to 60 people aged 65 and over. At the time of the inspection there were 39 people using the service, at our two other visits there were 37. The service is provided over two floors, with communal facilities being provided on the ground floor.

People's experience of using this service and what we found
The provider had not developed effective system in place to assess and monitor the service, nor were there effective systems to gather and analyse information. This has restricted the overall monitoring of the service and ineffective governance meant there was a lack of management oversight of the service.

We found that management of pressure care was inadequate. Skin integrity was not regularly checked and recorded and so there was no oversight of improvement or further deterioration.

Infection prevention and control was poor and there was no oversight with regard to the cleanliness of the premises or equipment. PPE was not always worn effectively and appropriately, and we did not see good hand hygiene practises even though government guidance is clear and has been throughout the pandemic.

Staff were not kept up to date with training, that meant that they were not receiving information on changing practises with regard to delivering care. There was insufficient staffing to ensure that people's needs were met, there was no accurate and up to date dependency assessment in order to calculate staffing levels in ratio to people's needs.

Rating at last inspection
The last rating for this service was requires improvement (published 31 December 2019)

Why we inspected
The inspection was prompted in part due to concerns received about pressure care, infection control and nutrition and hydration. A decision was made for us to inspect and examine those risks.

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

Follow up
We will be in contact with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This

means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not Safe.

Details are in our Safe findings below..

Is the service well-led?

Inadequate

The service was not Well-Well.

Details are in our Well-Led findings below.

Willow Tree House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by three inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. One inspector returned on the third visit, this was to check that improvements had been made.

Service and service type
Willow Tree House 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who commission some people's care at the service. We used this information to place our inspection. We also looked at notifications we had received about the service which triggered the inspection.

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

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with three members of care staff, the cook, the deputy manager, registered manager. two senior managers who were based at the service. We later spoke with the nominated individual.

We reviewed a range of records. This included 22 people's care records and multiple medication records. We looked at four staff files in relation to safe recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The assistant inspector spoke with nine members of staff by telephone and the expert by experience spoke with 20 relatives of people who were using the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- There was a lack of oversight with regard to managing and monitoring risk. The care plans and risk assessments we looked at had not been reviewed for long periods, some were up to three years. That meant that ongoing risks were not assessed, and people were not kept safe from avoidable harm. We were told that one person had issues with mobility and malnutrition and dehydration. When we checked the care plan mobility was there but nothing regarding nutrition and hydration. The lack of information poses a risk to the person not being adequately supported to eat or drink enough.
- Food was not stored safely or correctly. Fridge items had not been dated when opened this posed a risk of out of date food. Multiple packets of breakfast cereals had been emptied into a dustbin which meant there was no information on when the packet had been opened. When we returned on the second day, they had been put into more appropriate containers but were still not dated.
- People were not observing social distancing in the lounges or dining room. Staff had placed people next to one another which does not follow government guidance. People were just getting over an outbreak of COVID-19 and there was nothing in place to reduce the risk of infection spreading.
- We could find no evidence of learning lessons when things go wrong. Feedback was not sought from people and complaints were not dealt with in a timely manner if they were responded to at all.

The failure to mitigate risk and keep people safe is a breach of Regulation12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse.

- The safeguarding policy was out of date and related to legislation which was replaced in 2014 by The Care Act and lacked information on all types of abuse.
- Relatives told us they didn't feel people were kept safe. One relative said "We had a window visit and it was clear that the bed was soaked in urine and [name] looked poorly.'' Leaving people in wet pads and bedding posed a risk of skin breaking down and leading to infection.
- Referrals to health professionals were not timely and often overlooked. The lack of effective management of deteriorating health conditions, skin integrity and nutrition and hydration posed a risk of significant avoidable harm. A visiting nurse told us "I have concerns as I keep finding more pressure ulcers, they are obviously not checking people as they should when delivering personal care.''
- Staff told us that they were aware of safeguarding and how to report concerns. However, the majority of the concerns raised had been reported from families and visiting professionals and not from the service.

The failure to keep people safe from avoidable harm is a breach of Regulation 13 (safeguarding) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● There was no dependency assessment to calculate staffing levels based on the needs of people living at the service. This meant that there wasn't always sufficient appropriately trained staff to support people. We saw people waiting for support and one of the inspection team had to request a staff member to attend to one person in the dining room as staff had not noticed they required support.

● Staff told us that there wasn't enough staff. One staff member told us "some are woken up at 5am so that we can fit in getting everyone up.'' Another staff member said "One person didn't get down until 11.45 on Christmas day, we didn't have enough staff to get everyone up and dressed.''

● Staff training was out of date and new starters did not receive all of the training they needed prior to delivering care. There were 52 staff on the training matrix including management, 13 had up to date nutrition and hydration training, six had received tissue viability training, 19 had infection prevention and control and only five had been trained in food fortification. There were just 15 staff who had received training in PPE and only two members of staff had training in pressure ulcer prevention. These were all areas where we had found concerns during our inspection. There was no training on the record for COVID-19.

The lack of staffing to support people safely was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2001 (Regulations 2014)

● We saw evidence of safe recruitment taking place. We checked staff files and there was appropriate checks carried out prior to staff starting in their role.

Preventing and controlling infection

● The infection control policy was one page with very little information regarding the subject matter. It had no information on COVID-19, managing an outbreak or what cleaning measures should be in place. It also had no mention of Personal Protective Equipment.

● No additional cleaning had been implemented even when they were just recovering from an outbreak of COVID-19. There were no additional sanitising stations, additional cleaners had not been employed. Cleaning staff were utilised to assist people to eat at lunchtimes which meant that cleaning was not being carried out.

● We observed that the home was not clean. Equipment was not clean or sanitised between use, toilet seals were dirty. We mentioned this to the deputy manager who organised cleaning to take place. This should be part of the cleaning schedule to ensure all areas are cleaned frequently.

● Staff were not wearing appropriate Personal Protective Equipment (PPE). Gloves were not worn when supporting people to eat and drink and masks were not changed frequently. On our second visit we saw that some improvement had been made and staff were wearing PPE but still did not change between tasks.

Using medicines safely

● Management and storage of medication were managed well, however, we saw that when people were given medication, the staff did not sanitise or wash their hands between each person. This posed a risk of cross contamination and a high risk of infection.

● Staff responsible for the administration of medicine had undertaken training in the safe handling of medicine and had been assessed as competent. However, the person who was responsible for medication on the day of our inspection was new to the service and did not know the people living there.

● The medicines policy was poor and lacked detail on the storage, administration and disposal of medicines.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

- The provider did not have in place a system to assure themselves as to the quality of the service, in order to identify issues and make improvements. Any audits which were in place were not effective in giving management oversight and making improvements.
- The provider did not have a system to identify any themes or trends occurring within the service, for example learning from accidents and incidents through analysis and review.
- The registered manager had not recognised government guidance regarding the management of care during the pandemic. People were not socially distanced to prevent the spread of infection. Staff did not wear PPE appropriately and we observed them pulling masks down and standing close together when going outside for a cigarette, they did not change their masks when they re-entered the building.
- One staff member told us "the manager always has the door closed so we don't go to them.''

The lack of effective management oversight and effective system in place to assess, monitor and improve the quality and safety of the service is a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities).

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- We had received several complaints from relatives regarding the lack of information they had received from the registered manager. This was with reference to people being unwell, health deterioration and being tested positive for COVID-19. One relative told us that they had to intervene and contact health professionals as they had felt that management at the service were being obstructive.
- The manager was aware of compliance with duty of candour, however this was not always adhered to. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment.

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

- We could see no evidence of where people had been requested to give feedback. Relatives told us that they had not been asked and residents told us that when they had given feedback, it was not acted upon.
- We saw minutes of residents' meetings, but they were not effectively engaging people to participate. When

people did make a request, this was not actioned in a timely manner.

Working in partnership with others

● Professionals who visited the home told us that they had concerns regarding how people were cared for. The management were not proactive in identifying or reporting concerns and obtaining professional guidance.

● The registered manager told us that they had regular visits from professionals to support people using the service.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Infection prevention and control practises were inadequate, risk assessments and policies were out of date and quoting historic obsolete legislation.

The enforcement action we took:

Served a letter of intent followed by an NoP to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not kept safe from avoidable harm. Staff had not received training, care plans and risk assessments were out of date, Nutrition and hydration and skin integrity was not managed causing further health deterioration.

The enforcement action we took:

Served a letter of intent followed by a NoP to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lack of management oversight, inadequate monitoring of the home and inadequate action taken when people were at risk of deteriorating health conditions.

The enforcement action we took:

Letter of intent followed by a NoP to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not sufficient staffing to enable people to be supported and cared for appropriately, staff

Personal care	had not been trained adequately which left people at risk.

The enforcement action we took:

Served a letter of intent and followed by a NoP to impose conditions.