

Willow View Care Limited

Willow View 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 well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Willow View Care Home provides accommodation and residential care for up to 77 people, some of whom have a dementia related condition. The home comprises of two areas; Willow View which was the original building and the new extension wing, Willow Gardens. The two buildings were connected by a covered walkway. At the time of our inspection 58 people were living at the service.

People's experience of using this service and what we found

From 11 November 2021 anyone who enters a location which provides the regulated activity 'accommodation for persons who require nursing or personal care' must be double vaccinated against COVID-19 infection, unless they meet the exemption criteria set out by the Department of Health and Social Care. At this inspection we found three staff members who had not received any vaccinations. One staff member did meet the exemption criteria but had not self-certified or been asked to do so prior to 11 November by the registered manager. The other two staff were not medically exempt and had been allowed to work a number of shifts after the deadline. Although the provider addressed this following our feedback, they had been aware of the new legislation prior to our visit and had failed to act in a timely manner.

Medicines were not well managed, and unsafe medicine practices put people at risk.

Risks to people's health and wellbeing were not well managed. Risk assessments did not always accurately reflect people's current needs. Some risk assessments were not completed and others were not detailed enough to guide staff on how to safely support people.

Safe recruitment procedures were followed. Although records showed the home was staffed to a safe level, staff members, people living in the home and their relatives felt more staff were needed. Following our feedback, the registered manager was going to review the way staffing levels were calculated.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. We were not fully assured the service was following safe infection control guidelines in relation to COVID-19 and we have made a recommendation about this.

Records were not always fully completed or up to date. Audits that took place did not highlight all the concerns found on the inspection day.

Accidents and incidents were reviewed monthly for any learning outcomes.

Staff understood safeguarding procedures and how to report concerns.

Most of the staff we spoke with felt well supported by the management team. Further work was needed to improve communication with relatives and to involve them and people using the service, more.

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

The last rating for this service was Good (published 29 May 2019)

Why we inspected

The inspection was prompted in part due to concerns received about staff working without a vaccination. A decision was made for us to inspect and examine those risks. We carried out a focused inspection of this service on 22 November 2021. This report covers our findings in relation to the key questions safe and well led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Willow View Care Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to unvaccinated staff, risk management, medicines, and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Willow View Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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 two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

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

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

Notice of inspection

The 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 the service for some people who use the service and the Clinical Commissioning Group (CCG). We used all this information to plan our 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. We used all of this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and seven relatives. We spoke with nine members of staff including the registered manager, deputy manager, care staff, domestic and kitchen staff.

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

After the inspection

We requested further information and continued to seek clarification from the provider to validate evidence found.



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

Using medicines safely

- Medicines were not managed safely
- Controlled drugs were not checked in line with the homes policy and we found discrepancies with the count of one controlled drug.
- The service used an electronic system for monitoring and recording medicine administration. Medicine counts on the system did not match what was in stock at the home.
- Guidance to support staff in the safe use of when required medicines was not always in place.
- Topical medicine application charts were not in place for all creams. Where charts that were in place they did not always contain the correct information or instructions for staff.
- In one treatment room, there was no recording of the temperature of the room. An eye drop that was supposed to be stored in the fridge was left at room temperature and the date of opening of medicines with a short shelf life was not recorded.

Medicines were not administered or managed safely. These findings evidenced a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management

- People were exposed to risk of harm due to a lack of person-centred risk assessment. Risk assessments did not always accurately reflect people's current needs. Some risk assessments were not completed and others were not detailed enough to guide staff on how to safely support people.
- A body map in one person's care plan identified concerns about their skin integrity. However, there was no care plan or risk assessment to inform staff of the correct way to support this person.
- Prompt action was not taken when routine checks identified possible cause for concern. The homes used National Early Warning Score (NEWS) system to monitor people's clinical observations such as blood pressure, pulse and oxygen levels. Some of the results indicated possible cause for concern and that further action should be taken but there were no records to show this was done. One person had lost a significant amount of weight over a short period, but the dietician was not contacted for over a week and they were not weighed again for two weeks.
- Work was needed to make fire drills more robust. For example, drills were not repeated when staff had not responded appropriately.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated

Preventing and controlling infection

- From 11 November 2021 anyone who enters a location which provides the regulated activity 'accommodation for persons who require nursing or personal care' must be double vaccinated against COVID-19 infection, unless they meet the exemption criteria set out by the Department of Health and Social Care. At this inspection we found three staff members who had not received any vaccinations. One staff member did meet the exemption criteria but had not self-certified or been asked to do so prior to 11 November by the registered manager. The other two staff were not medically exempt and had been allowed to work a number of shifts after the deadline. Although the provider addressed this following our feedback, they had been aware of the new legislation prior to our visit and had failed to act in a timely manner.

These findings evidenced a breach of Regulation 12 (3) (Safe care and treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014

- We were not assured that the provider was preventing visitors from catching and spreading infections. On entering the home, no checks were done to ensure we had been doubly vaccinated or had taken a COVID-19 test. We did see evidence that checks had been done for some visitors however a visiting professional told us they had not been asked to show evidence of vaccination.
- Staff were not always appropriately cohorted to designated areas of the home to reduce the spread of infection. The registered manager told us staff worked on the same floors at all times. However, on the day of inspection one staff member was working on both floors of Willow Gardens. At the time one of these floors had people who were COVID-19 positive. We were told this was due to staffing levels and there was an ongoing recruitment campaign.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured that the provider was accessing testing for people using the service and staff.

We recommend the provider ensures all visitors are checked prior to entering the home and staff don't work over different floors, especially during a COVID-19 outbreak.

Staffing and recruitment

- The home was staffed in line with the recognised needs of the people living there. Staffing levels were calculated each month by taking into account each person's support needs. This was also updated if there was a change to a person's needs during the month.
- Although the home was staffed according to these calculations we received mixed feedback about staffing levels. One member of staff told us, "There are lots of staff complaining about staffing levels, we can't go on working like this." Another member of staff said, "We have had an issue with staffing levels but I think it's been because of staff illness and holidays. I do think the staffing levels are safe."
- We also received mixed feedback from people using the service and their relatives about staffing levels. One relative told us, "I know sometimes [Name] presses their bell and no one comes for some time, but then other times they come within 30 seconds. We know they struggle with staff and that it is difficult to sustain staff numbers." A person living in the home said, "I definitely feel safe, I feel wonderful in that respect. If you press your button [staff] are here." We discussed this with the registered manager who told us they would review their dependency tool and speak with people about their concerns.

- Staff had been recruited safely and robust pre-employment checks had been carried out.

Learning lessons when things go wrong

- The provider had systems for monitoring incidents and accidents. We found accident and incident records were completed and monitored by the registered manager to reduce the likelihood of reoccurrence.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. People told us they felt safe with staff who provided care and support to them. Comments included, "Yes, I feel very safe, I know that they are always looking after me, they keep watching out for me and they look in my room all the time" and "I'm happy and safe here."
- Staff were trained to identify and report abuse and knew how to escalate any concerns.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Audit systems were not robust enough to identify the shortfalls we found. The medicines audit we were shown lacked detail and answers were not always consistent with our findings.
- Records were not always fully completed or up to date. We identified a number of examples where the care plans and risk assessments did not fully reflect people's current needs.
- The provider had not taken sufficient action to ensure staff who worked at the home were fully vaccinated.

Systems were either not in place or not robust enough to oversee the quality of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We saw very little evidence that people were involved and engaged with the service. Relatives and resident meetings took place but no one attended. The last fully attended meeting was in 2018. Drop-in sessions had not been successful either. The registered manager told us they were looking at alternatives but in the meantime they made an effort to speak with relatives when they visited the home.
- We received a mixed response from relatives about communication with them. One relative told us, "They didn't tell us about the COVID-19 outbreak and had shut down. I had a wasted journey down there to find out and not be able to get in" another relative told us, "Up until recently the communication was good."
- Staff meetings took place and were well attended.
- The majority of staff we spoke with said they felt supported by the registered manager. Comments from staff included, "I think the management are really good" and "[Registered manager] is very supportive."

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 found the registered manager to be open and honest throughout the inspection day. They acknowledged the issues we highlighted and knew what work they needed to do to make the necessary improvements.
- The registered manager understood their role in terms of regulatory requirements. For example, notifying

CQC of events, such as safeguarding's and serious incidents as required by law.

Continuous learning and improving care; Working in partnership with others

- The management team were open and responsive to our inspection feedback.
- The service worked in partnership with health and social care professionals who were involved in people's care.

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 12 HSCA RA Regulations 2014 Safe care and treatment
	Unvaccinated staff had been allowed to work following the change in legislation. 12(3)
	Medicines were not safely managed 12(2)(g)
	Risks were not being correctly assessed and risk assessments did not always contain sufficient information to mitigate risk. 12(2)(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	Systems and processes in place to monitor the quality and safety of the service were not effective. 17(2)(a)
	Care records were not accurate, complete or up to date. 17(2)(c)