Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Willow House

Willow House, 101 Countess Road, Amesbury, Salisbury, SP4 7AT

Tel: 01980622220

Date of Inspection: 17 January 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Sharon and Glen Arnott
Registered Manager	Mrs. Sharon Arnott
Overview of the service	Willow House provides care, support and accommodation for up to nine adults with a learning disability, many of whom are aged over 65 years. Sharon Arnott, one of the providers of the service, is also the registered manager.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, reviewed information sent to us by the provider, carried out a visit on 17 January 2013 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

What people told us and what we found

Summary

A person told us they were confident in staff knowledge of them as an individual. They told us "Staff check out how I am, this is home to me." The provider had equipped this person's room with a new fire exit and hoisting equipment so they could return to the home from hospital.

We found staff had a wide knowledge of people's interests and abilities, which was used to support people to maintain activities relevant to them. Staff offered people choices and showed understanding of how people communicated. A person's relative told us they had always been able to share their views with the staff and management. They felt included in how the home planned for meeting their relative's needs.

The home liaised with community health services. Staff kept full notes of changes in people's wellbeing and requested medical attention for people in a timely way. Staff provided care and support in line with people's care plans.

Staff felt confident in their understanding of and ability to work with people's behaviours. They were clear about their safeguarding responsibilities and how they would respond to any suspicion of abuse.

All staff received regular supervision. Staff members told us this helped build on strengths and support development. One support worker told us "You always know where you stand."

The providers had systems for continually monitoring the quality of care and support provided. They used feedback from all people with an interest in the service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We spoke with a person whose care needs had significantly increased following a medical trauma in another setting. They told us they had asked to return to Willow House because they were confident in staff knowledge of them as a person. They told us "Staff check out how I am, this is home to me." The provider had equipped their room with a new fire exit and hoisting equipment so they could return to the home. A staff meeting was held with the person in their room, so they were fully involved in how their care was provided. They told us staff agreed their aim to work towards renewing activities they had enjoyed in the past, as their condition improved.

Care plans we looked at contained life books and profiles of people. We found staff had a wide knowledge of people's interests and abilities, which was used to support people to maintain activities relevant to them. People attended a variety of clubs and day resources, as well as going out for shopping and social visits. Staff and the providers told us of adjustments made or planned to reflect the changing needs of some people as they got older. For example, some people needed to rest more or to have more aids for getting around the home.

All interactions we saw between staff and people living in the home were positive. Staff offered people choices and showed understanding of how people communicated. Care plans contained guidance to people's communication needs. A person's communication support plan reminded staff to ensure the person's spectacles and hearing aid were kept in perfect working order, as well as describing their preferred communication methods. There was evidence of current work on developing 'objects of reference' as a communication strategy for some people. We saw a communication passport that had been developed with one person and their family. It contained photographs of the person in different situations, with an emphasis on supporting the person to get the most out of any situation. The person's care plan contained a pictorial assessment of their needs.

We saw that people were kept informed of changes in the home by residents' meetings, as

well as informally through every day conversation in the sitting room and at the meal table. A newsletter was sent to people's families twice a year. This routinely reminded people that feedback of people's experiences was welcome at any time. A person's relative told us they had always been able to share their views with the staff and management and they felt included in how the home planned for meeting their relative's needs. Care plans showed evidence of agreement by people or their close relatives.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Care plans were linked to risk assessments and were person centred. For example, a person's personal hygiene support plan directed staff how to engage successfully with the person to encourage them to accept and cooperate with the assistance they needed. The provider may find it useful to note that activity care plans did not identify outcomes, for example physical or social, that people might seek to achieve through participation in different kinds of activities.

Staff we spoke with were very familiar with the care plans. They told us they were informed of all changes through handovers and staff meetings. They saw it as a shared responsibility of all the staff group to ensure care plans remained up to date in reflecting people's care needs and how to met them. Staff had key worker responsibilities. This meant each person living in the home had one support worker who particularly monitored their needs and acted as a link with the whole staff group. The manager told us each staff member was given designated time twice a year to read all the care plans in detail.

One person needed to spend long periods of time in bed. Records showed they were receiving daily visits from the district nursing team and were supported by a community spinal injuries nurse. Care planning documentation in their room showed there was an agreed plan of care shared by district nursing and home staff. This gave the person protection against developing pressure ulcers. For example, records showed staff assisted the person to adjust their position at set times in the day and to maintain a healthy fluid balance. Specialist equipment was provided, with evidence of external professional liaison and staff training. Night time staffing of the home had been increased to ensure the person's needs were met. The person was assisted to spend time in the communal parts of the home and to receive visits from others in the home when they chose.

Records available in the home and notifications they have sent us about incidents in the home showed there was a high level of liaison with community health services. People received annual health checks. There was a plan for ensuring people kept routine appointments with dentists, opticians and other professionals relevant to individuals. Staff kept full notes of changes in people's wellbeing and requested medical attention for people in a timely way. Where people needed an epilepsy profile, this was up to date and was reflected in other parts of their care plans and risk assessments.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Training records showed all staff were up to date with training in abuse awareness, safeguarding and the Mental Capacity Act 2005 (MCA) as it related to their work. Monthly staff meetings included a training element, which once a year was a refresher on safeguarding training, with assessment questions set. MCA training included Deprivation of Liberty Safeguards (DoLS). The manager told us they had discussed a possible DoLS issue with the local authority specialist advisor and were advised a referral did not need to be made.

Where people displayed behaviours that others could misinterpret or find challenging, related care plans gave an explanation and guidance to staff on how to support the person. The plans emphasised that behaviour was a form of communication to be understood and engaged with. Staff we spoke with felt confident in their understanding of and ability to work with people's behaviours. They were clear about their safeguarding responsibilities and how they would respond to any suspicion of abuse. The manager or a senior member of staff was available on call to the home at all times.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

The service received a positive assessment from Investors in People in March 2012, which demonstrated a commitment to improvement through staff training and supervision. A senior member of staff had a training and development lead role. There was a clear process in place to ensure refresher training in mandatory subjects was delivered on time, using a recognised distance training provider. A monthly training report showed completions of training and identified any workbooks not yet returned for marking.

Each member of staff, including the manager, had a personal training plan, which showed what they had accomplished and when renewals were due. Mandatory training included food hygiene, first aid, moving and handling and safeguarding. Some training was specific to the needs of people in the home, such as epilepsy and administration of recovery medicines. There was a high level of achievement of National Vocational Qualifications (NVQ, now Diploma in Health & Social Care) from level 2 to 4. One member of staff was serving an apprenticeship.

All staff received monthly supervision, or two-monthly for part time workers, from the manager or a senior member of staff. Records confirmed the frequency of supervision meetings was maintained. Staff were required to submit a pre-supervision form to help set an agenda. Questions helped identify issues including training needs or requests and changing care and support needs of people living in the home. Notes of the content of supervision, which included objectives set, were signed by both people involved. Staff told us they valued this model of supervision. They felt it helped build on strengths and support development. One support worker told us "You always know where you stand." We saw that staff also received annual appraisals.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received. There was an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

We saw a management report that was shared with staff of the service in December 2012. This showed the current priorities for the providers and progress being made against them, and summarised the main issues for people currently living in the home.

The manager met with senior staff every week for an informal meeting that was not minuted, whilst there was a formal meeting with minutes once a month with all of the staff team. This was repeated in the evening for the benefit of night staff. Staff told us they felt continuously involved in the service and saw their views and ideas as valued. Some roles were delegated to members of the staff team, such as infection control, fire safety and dementia champion. There were clear arrangements in place for responsibilities during any absence of the providers.

Meetings were held for people living in the home to give and receive feedback. There was an annual questionnaire survey undertaken with people in the home, relatives and professionals who visited the home. The most recent survey had produced entirely positive responses.

Staff made full records of all incidents and accidents. There was evidence these were always reviewed quickly by the providers. For example, an accident that occurred on the stairs led to immediate analysis and environmental adaptation to minimise risk of recurrence. We saw that changes in medicines practice had been made as a result of a medicines audit carried out by the manager.

There was an annual plan showing when various audits, equipment servicing and environmental checks were to take place. Fire safety procedures were reviewed quarterly and there was evidence of evacuation practices. The manager used CQC's provider compliance assessment tool as a check that systems to monitor and maintain quality standards were in place and reliable. A member of staff from another service operated by the providers undertook a monthly quality audit.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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