

St. Martin's Care Limited

# Willow Green Care Home

## Inspection report

Eastborne Road  
Darlington  
County Durham  
DL1 4ER

Tel: 01914670036

Website: [www.smcgroup.co.uk/our-homes/willow-green](http://www.smcgroup.co.uk/our-homes/willow-green)

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## Ratings

Overall rating for this service

Good ●

Is the service effective?

Good ●

Is the service well-led?

Good ●

# Summary of findings

## Overall summary

This focused inspection took place on 7 November 2018 and was unannounced.

We completed an unannounced comprehensive inspection of this service in February 2018. After that inspection we received concerns regarding the management and governance within the home and how people's care, treatment and support needs were being delivered. Concerns were also raised as to whether staff had the skills, knowledge and experience to meet the needs of the service. Concerns that people were not receiving an appropriate level of nutrition and hydration. Lack of consent for care and support delivery and issues with the environment not being appropriate to meet people's needs.

As a result, we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (St Martin's Care Limited) on our website at "[www.cqc.org.uk](http://www.cqc.org.uk)"

The team inspected the service against two of the five questions we ask about services: is the service effective and is the service well led? No additional risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Willow Green 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.

The care home accommodates 63 people across two floors. At the time of the inspection 53 people were being supported in the home, 20 of which were receiving nursing care.

The service did not have a registered manager. A new manager was in post who had commenced the process to become the registered manager of Willow Green.

'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

Some people felt the quality of the food needed improving. Plans were in place to address this with the development of new menus. A new chef had been employed.

People's needs were assessed in line with best practice and current legislation to ensure they could be supported in Willow Green. People's likes, dislikes and preferences were used in planning outcomes. Staff

were aware on how to provide support and guidance to meet people's outcomes.

Staff told they felt supported and received regular supervision and annual appraisals. Staff had received appropriate training to meet the needs of the service. The manager had planned in additional training for staff to completed to increase their skills and knowledge.

People were supported to have maximum choice and control of their lives, and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People had their nutritional needs assessed regularly and were supported to eat and drink safely. Where specialist diets and thickened fluids were required, these were provided. People's health was monitored and when necessary staff ensured people had access to health care professionals when necessary. The provider had commenced a programme of refurbishment with some rooms being redecorated. The reception carpet was due for renewal. Rooms were personalised to people's taste. Communal areas were spacious and accessible. People had access to outside areas. The home was clean with no odours.

The provider's senior management structure had been revised. Senior management were improving systems and processes within the service and increasing their presence to support staff and the home's management. Audits were in place which were used as part of service improvement.

The new manager had only been in post for a few weeks. Staff were already positive about the changes they had made. They confirmed they felt supported and could raise concerns. Staff all commented on how they felt so happy when the manager returned and the mood in the home has lightened and everyone is a team again. One staff member told us "There is an open and honest culture here now which makes for a good feeling in the home both for residents and staff".

We observed the manager was visible in the service and found people interacted with them in an open manner. People and relatives felt the management approach in the home was positive.

Links with the local community were in place. Partnership working with other agencies, commissioning and local health and social care teams was in place.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service effective?

Good ●

The service was good.

### Is the service well-led?

Good ●

The service was good.

# Willow Green Care Home

## Detailed findings

### Background to this inspection

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

We completed an unannounced comprehensive inspection of this service in February 2018. After that inspection we received concerns regarding the management and governance within the home and how people's care, treatment and support needs were being delivered. Concerns were also raised as to whether staff had the skills, knowledge and experience to meet the needs of the service. Concerns that people were not receiving an appropriate level of nutrition and hydration. Lack of consent for care and support delivery. Issues with the environment not being appropriate to meet people's needs.

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This inspection was undertaken by one adult social care inspector, one assistant inspector and an expert by experience.

Before the inspection, we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are reports about changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also spoke with the Local Authority commissioning team.

During our inspection we spoke with nine people who used the service and five relatives. We also spoke with the manager, deputy manager, head of care and quality partner, the clinical lead, one nurse, two senior carers, the activity coordinators and assistant coordinators and eight care staff. We also spoke with three health and social care professionals.

We looked at three people's care records, as well as records relating to the management of the service. We looked around all the bathrooms and communal areas.

We did not carry out a short observational framework for inspection (SOFI) because people were able to communicate with us. This method of observation is used to capture people's experiences who are not able to voice them. We did however spend time in communal areas to observe staff interaction with people.

## Is the service effective?

### Our findings

We have inspected this key question to follow up the concerns we received regarding how people's care, treatment and support needs were being delivered. Concerns as to whether staff had the skills, knowledge and experience to meet the needs of the service. Concerns that people were not receiving an appropriate level of nutrition and hydration. Issues with the environment not being appropriate to meet people's needs.

We saw people's needs were assessed before they started using the service. Records detailed people's needs and choices. The provider used legislation and best practice to inform their assessments. For example, moving and assisting guidance. The provider used a "How best to care for me and my outcomes" document to provide staff with guidance.

The staff we spoke with had a clear understanding of people's assessed needs and how they wished to be supported and cared for. One person required one to one support as they were at risk of falls, we observed how the staff member interacted with the person, guiding them to keep them safe in terms of mobility. Another person required support with communication, we found staff used facial expressions, gestures and body language to interact. Where people were becoming distressed or agitated, staff were quick in providing reassurance and distraction techniques.

We found people's outcomes in terms of personal care were being met. People were supported to have baths or showers which ever was their preference. People's appearance was respected by staff, where necessary people were supported to change items of clothing to preserve their dignity. We found where people preferred not to wear socks or/and footwear this was recorded in care notes. One person told us, "I know about my care plan and, yes I get the support I need in a way that works for me." Another said, "I had an assessment and we talked about what I need and how the girls will help me, and they do."

Essential training was completed as part of the induction process. Essential training is training that the provider deems necessary to support people safely such as moving and handling and safeguarding. We found training was refreshed on a regular basis. Staff training needs had been identified by the management of the service using a new matrix. The manager and training co-ordinator had ensured staff were booked onto relevant training courses to develop their knowledge and skills.

People and relatives felt staff were trained appropriately. One person told us, "Staff are into training and the whole place has become a happy home." Another said, "They [staff] so know what they are doing, [I have] no worries at all."

Staff told us they felt supported and received regular supervision and an annual appraisal. We found supervisions took place regularly. One staff member told us, "Things are a lot better now." Another told us, "There are meetings, and we have our supervisions. We are more supported now and that is great for the whole home."

The Mental Capacity Act 2005 [MCA] provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act.

We found the service was working within the principles of the MCA. The manager had a good understanding of mental capacity, and staff had been trained in the MCA and deprivation of liberty safeguards (DoLS). Where a person had a lasting power of attorney (LPA) in place, copies of the legal documentation were held on their care file. Details of the LPA and their contact details were available for staff.

We found one occasion where consent had not been gained regarding the administration of medicines. This had been fully investigated by management with lessons learnt from the incident shared with nursing staff.

People were supported with their nutritional needs. Where necessary (speech and language therapist) SALT guidance was included in the person's support plan for staff to follow. Staff we spoke with understood the need for food to be of a specific consistency and how to prepare thickened fluids. We found where people required food and fluids to be recorded these were completed daily and reviewed by senior carers and/or nurses.

We saw people were assisted with meals where necessary. Drinks were available all day, either from the morning or afternoon tea trolley or from the small kitchen area on each unit. We observed staff offering drinks and snacks through the day. One staff member told us, "We offer fruit and have bowls of fruit ready if people want one." Another said, "Hot chocolate and Horlicks are offered, usually on a night time."

We received some negative comments regarding the food. One person told us, "I really don't like the food in here, if I wanted a pork pie with a hard crust I would buy a shop bought one". Another person told us, "I cannot eat some things, but there is always an alternative." A third told us, "It's OK I think." Staff also felt the food needed to improve. One staff member told us, "Some meals are fine but some are not." Another said, "We've got a new chef in the kitchen and they are slowly changing things." The manager had identified concerns around the quality of the food. Steps were in place to ensure people were involved in the development of new menus so likes and preferences were included.

Care files contained records to identify when professionals had been requested by the home as part of people's health care. For example, referrals to community nurses, chiropody and GP's. People and relatives told us health needs were addressed. One person told us, "I recently had a nasty cough and the staff notified the family and called the GP. I was on medication by the afternoon, that's quicker than when I was at my own home." One relative told us, "We get calls if our relative is unwell and the manager always ensures a quick visit by a GP or District Nurse." Another said, "My relative has the services of all the major high street companies for eye tests and hearing checks and also the dentist. If there was anyone else needed like the chiropodist then that would be fine."

The manager spoke about 'bringing the home into 2018,' and told us, "When I came into this home, the chairs were around the outside of the rooms, they're not anymore. There were no pictures on the walls." Regular funds had been allocated to improve the environment with plans in place to replace flooring, renovate dining areas and complete decoration of the dementia unit within six months. We saw examples of rooms which had been recently refurbished and furniture had been rearranged which created a warm and welcoming feel.

Bedrooms were personalised to people's individual taste, containing personal effects and pieces of furniture brought from home. Bathrooms were designed to incorporate needs of the people living at the home. There were several communal areas for people to socialise or spend time with visitors. The garden area was accessible to people and relatives. The manager advised a new carpet was due to be fitted in the reception area. The home was clean with no odours.

## Is the service well-led?

### Our findings

We have inspected this key question to follow up the concerns we received regarding the management of the home.

The service did not have a registered manager at the time of inspection. After a period of unsettlement and high turnover of registered managers, the company's senior management structure had been revised. The current manager, at the time of our inspection, had previously managed the home some months ago and following this change had again applied to be the manager. The manager had began the registration process with CQC. Staff were complimentary about the management of the service. Staff told us, "Things are a lot better since the last manager," and said about the clinical lead, "I find her approachable. I can ask her and she'll show me how to do anything clinically. I never feel belittled."

Concerns were raised that management failed to act on staff concerns. We found where issues had been raised by staff, records of investigations were available. These were completed by management and used by the head of care to review quality. Records were thorough and contained actions to improve the quality of the service.

Concerns had been raised regarding the amount of time people waited for support. As part of the new management systems, the staffing levels had been reviewed, the provider used a dependency tool to ascertain safe levels of staff to meet the needs of the service. We found where necessary, additional staff were brought in to provide one to one care. One agency nurse told us, "Staff are very nice, there's good staffing levels and the staff are very responsive." Buzzers were answered in a timely manner. One person told us, "You never hear a buzzer ring for more than a few seconds and I have never waited for help which makes me feel less embarrassed about asking for support."

Outcomes of staff meetings were not always acted upon successfully. The manager had identified the need to improve the quality of food. A meeting with catering staff had taken place, however we received negative feedback about the quality of food. Therefore, we suggested ensuring that outcomes of meetings were implemented and recorded and checked by management. Meeting minutes held by previous management demonstrated that meetings were held on a regular basis and gave staff the opportunity to voice both positive and negative feedback.

People, relatives and staff felt the management had improved. They were all pleased that the new manager was back in post. Comments included, "Things are much better now," and, "[Manager] listens, that is what we need," and, "Oh lovely, always smiling as they go around." We found the manager was visible in the home, we saw positive interaction with people and relatives.

Management were also keen to introduce systems to improve people's experience of care whilst using the service. There were plans in place to allocate each person their own keyworker to ensure their needs and wants were identified in a timely manner. The service was goal orientated and wanted to introduce a 'Three wishes programme' in which each resident made three wishes to achieve in three months with the support

of the service and its staff. The service wanted to reinstate its 'Resident of the day' system, in which one resident daily has their care plan reviewed, room thoroughly cleaned and a review of their needs and care package. The Head of Care also wanted to ensure the service had designated 'champions' which would be trained in specific areas such as dementia, safeguarding and dignity, to instil good values across the service.

Senior management were improving systems and processes within the service and increasing their presence to support staff and management. We saw quality audits were completed regularly, by appointed person's, following a quality audit schedule which included care plans, incident and accident analysis. New quality care and compliance tools would be completed by both the Head of Care and Quality Partner. The service would then complete action plans to improve the service, following the audit, with senior managements support. The Head of Care also told us they were planning to implement a 'Managers bookcase' after identifying that some key documents were unnecessarily complex. This system would ensure the service could operate effectively in the absence of the registered manager.

Senior management welcomed feedback and saw this as an opportunity to improve. We saw examples of newly developed resident's surveys available in different formats. The Accessible Information Standard was introduced by NHS England in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. Surveys were being developed in larger fonts with coloured backgrounds as well as in pictorial format for people with dementia or other sensory needs. A new questionnaire was also being developed for people attending the service for respite to ensure they captured as much feedback as possible.

Management took appropriate action to significant events. Services that provide health and social care to people are required to inform CQC of deaths and other important events that happen in the service in the form of a 'notification'. The manager told us they would notify relevant persons of any event saying, "I would rather be told I didn't need to put one in than have not put it in!" We saw examples of these notifications to both CQC and the Local Safeguarding Authority during her time in post. Records relating to people and the service were held securely.

We found evidence of partnership working with the Local Authority and the Clinical Commissioning Group. Links with the community were in place. People accessed local areas with support from staff and enjoyed visits from local entertainers.