Willowbeck Health Care Limited

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## Inspection report

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Date of inspection visit:
11 October 2016

Date of publication:
31 October 2016

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection took place on 11 October 2016 and was unannounced, which meant no one working at the home knew we would be inspecting the service. The care home was last inspected in January 2014 when it was found to be meeting the Regulations we assessed.

Willowbeck provides nursing and personal care for to 82 younger adults. The beds are divided into five individual units, catering for the needs of younger adults between the ages of 18-65 years old. Two units support people with complex physical disabilities, including critical care needs, and two units care for people with mental health problems, whose behaviours may challenge. At the time of our inspection the fifth unit was not operational. All bedrooms are single with ensuite toilets and are located across two floors. Lounge and dining areas are situated within each unit. The home has a garden area, a car park and is close to a bus stop.

The service did not have a registered manager in post at the time of our inspection. However, the deputy manager, with support from senior managers, was overseeing the day to day operation of the home. 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 and associated Regulations about how the service is run.

People who used the service, and the relative we spoke with, told us they were happy with how care and support was provided at the home. They spoke positively about the staff and the way the home was managed. Everyone we spoke with told us the staff were very good and they felt safe living at Willowbeck.

We saw there were systems in place to protect people from the risk of harm. Staff we spoke with were knowledgeable about safeguarding people and were able to explain the procedures to follow should an allegation of abuse be made. Assessments identified risks to people and management plans to reduce the risks were in place to ensure people's safety.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a good understanding and knowledge of this topic. People who used the service had been assessed to determine if a DoLS application was required.

Systems were in place to ensure people received their medications in a safe and timely way from staff who were appropriately trained. We found the majority of the time staff had followed the correct procedures. However, we identified some minor concerns in respect to recording and reviewing medication. These were resolved at the time of the inspection.

There was enough skilled and experienced staff on duty to meet people's needs. Recruitment systems were robust, so helped the employer make safer recruitment decisions when employing new staff. New staff had

received a comprehensive induction into how the home operated and their job role. This was followed by regular refresher and specialist training to meet the needs of the people using the service.

People were supported to eat and drink sufficient to maintain a balanced diet and adequate hydration.

People's needs had been assessed before they moved to the home and we found they, and if required their relatives had been involved in the planning care. Care files checked reflected people's care and support needs, choices and preferences. However, we found the care files on one unit were difficult to follow, due to the way they were organised and the amount of out of date information stored in the files.

People had access to a varied programme of activities which provided regular in-house stimulation, as well as trips out into the community. People said they enjoyed the activities they took part in.

A complaints policy was available to people using and visiting the service. The people we spoke with told us they had no complaints, but said they would feel comfortable speaking to staff if they had any concerns. We saw when concerns had been raised they had been investigated and resolved in a timely manner.

There were extensive systems in place to monitor and improve the quality of the service provided. However, these had not always identified areas that needed improvement. Therefore timely action had not been taken to address inconsistencies on the different units.

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

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People told us the home was a safe place to live and work. Staff had received information and training about how to recognise signs of potential abuse, and were aware of reporting procedures. Assessments identified risks to people and plans were in place to manage any identified risks.

Recruitment processes were thorough which helped the employer make safer recruitment decisions when employing new staff. There was sufficient staff on duty to meet people's needs.

Systems were in place to make sure people received their medications safely, which included key staff receiving medication training.

### Is the service effective?

Good

The service was effective.

Staff had completed training in the Mental Capacity Act and understood how to support people whilst considering their best interest. Care records incorporate detailed information about decisions made in people's best interest.

A structured induction and training programme was available which enabled staff to meet the needs of the people they supported.

People received a well-balanced diet that offered variety and choice. The people we spoke with said they were happy with the meals provided.

### Is the service caring?

Good

The service was caring.

People were treated with respect, kindness, compassion and consideration.

Staff demonstrated a good understanding of how to respect people's preferences and ensure their privacy and dignity was maintained.

We observed that staff took account of people's individual needs and choices, while supporting them to maintain their independence.

## Is the service responsive?

Good

The service was responsive.

People had been encouraged to be involved in care assessments and the planning of their care. Care plans provided detailed information to help ensure staff met people's individual needs and preferences.

People had access to various activities and outings into the community, which they enjoyed.

There was a system in place to tell people how to make a complaint and how it would be managed. People told us they would feel comfortable raising any concerns with the management team.

## Is the service well-led?

Requires Improvement

The service was not always well led.

The service did not have a registered manager, but appropriate management support was available.

Questionnaires, care reviews and meetings had been used to ask people if they were happy with the care and support provided, as well as how the home was run.

There were systems in place to assess if the home was operating correctly. However, these were not always effective as they had not identified the areas for improvement we found.

Staff were clear about their roles and responsibilities and had access to policies and procedures to inform and guide them.

# Willowbeck Health Care Limited

**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.

The unannounced inspection was carried out by two adult social care inspectors on 11 October 2016.

Before our inspection, we reviewed all the information we held about the home. We also asked the provider to complete a provider information return [PIR] which helped us to prepare for the inspection. This is a document that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also contacted the local authority and Healthwatch Sheffield, to gain further information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of the visit there were 52 people using the service. We spoke with 12 people who used the service and a visitor. We also spent time observing how staff interacted with, and gave support to people.

We spoke with the operations manager, operations support manager, deputy manager, a clinical nurse manager, six nurses, six care workers, the lead activities coordinator, as well as one of the housekeeping team.

We looked at documentation relating to people who used the service and staff, as well as the management of the service. This included reviewing four people's care records in detail, with an additional two in relation to the Mental Capacity Act, nine staff recruitment and support files, the staff training matrix, medication

records, audits, policies and procedures.

Good

# Is the service safe?

## Our findings

People we spoke with said they felt the home was a safe place to live and work, and our observations confirmed this. We saw care was planned and delivered in a way that promoted people's safety and welfare. Records were in place to monitor any specific areas where people were more at risk, and explained to staff what action they needed to take to protect them. Assessments covered topics such as poor nutrition and moving and handling people safely. We also found equipment such as specialist beds, bed side safety rails and pressure relieving equipment was used if assessments determined these were needed.

Appropriate equipment and arrangements were in place in case the building needed to be evacuated, with each person having their own evacuation plan.

Policies and procedures were available regarding keeping people safe from abuse and reporting any incidents appropriately. The staff we spoke were knowledgeable about safeguarding people and the companies whistle blowing policies and procedures. Whistleblowing is one way in which a staff member can report suspected wrong doing at work, by telling someone they trust about their concerns. Staff said they would not hesitate to report any safeguarding concerns. They told us if they felt senior staff were not responding appropriately they would report concerns to the operations manager or the local authority.

We found that overall there was enough staff to meet the needs of the people being cared for at the time of our inspection. However, staff rotas were not clear as they had gaps and did not have a key to explain what certain entries meant. For instance, it was difficult to track which staff had covered identified shortfalls on the rotas. We later found these were recorded on a separate sheet within the file. We also saw entries such as 'TD', which we later found out meant training day. We spoke with the management team about this and they said they would consider adding a key to the rota.

Staff we spoke with confirmed that predominantly there was enough staff on duty to meet people's needs. Our observations identified people's needs were met in a timely way and staff were present in communal areas. We saw assessments in care files that identified people's dependency needs which the management team used to calculate how many support and care hours were required. However, it was not clear how often these were reviewed to ensure the staffing levels were still appropriate. Staff told us staffing levels were reviewed daily and increased when needed. For instance, one member of staff described how recently an extra half shift had been covered to provide additional support to meet someone's changing needs.

We found a robust recruitment and selection process was in place, which included new staff receiving a structured induction to the home. We sampled four recently recruited staff files which contained all the essential pre-employment checks required. This included written references, and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. We found the professional qualifications of nursing staff were also regularly checked to ensure they were registered to work as a nurse, and maintained their registration.

Staff we spoke with confirmed the recruitment process. They said they could not start work until satisfactory references and a DBS check had been obtained.

We looked at the systems in place for managing medicines across all four units in the home. This included the storage, handling and stock of medicines and medication administration records (MAR). We found medication was stored correctly and temperatures with the rooms they were stored in and refrigerator temperatures being regularly monitored.

Overall we found medication was managed safely and records were robust. However, on two units we saw staff had not always recorded the amount of medicines received or the amount carried forward from the previous month, which made it difficult to account for medicines. For instance, when we checked one person's stock against the records we found the error was because there were two boxes in stock, but the second box had not been recorded on the MAR. We also found that one person's pain relief had not been reviewed that day to assess its effectiveness.

The majority of people had a protocol in place when prescribed medication to be taken 'as and when required' [PRN]. For example for pain relief and to alleviate agitation. These detailed when to give PRN medication and explained how people presented when they were in pain or agitated. However, not everyone prescribed PRN medication had a protocol in place. Staff told us people who were prescribed these medications were not always able to tell them when they were in pain or distressed due to their medical conditions. This meant that people who used the service could be in pain or distressed and not have medication administered in a timely manner, as new and temporary staff may not know what signs to look for to determine when it was required. These were addressed during our inspection.

We discussed our findings with the operations manager during the inspection who agreed to carry out a full medication audit and implement more robust systems to ensure any errors were identified in a timely way. Following our inspection the operations support manager confirmed audits had been completed and action taken to address the issues we, and their audit, found.

Good

# Is the service effective?

## Our findings

Staff we spoke with all said the training provided was good and they could access service specific training to ensure they understood people's needs. A relative told us they found staff to be good communicators, friendly and efficient at their job.

We found all new staff completed the company's seven day mandatory training, which included moving people safely, health and safety, food safety and safeguarding vulnerable people from abuse. Staff told us they had also shadowed experienced staff as part of their induction. The company were aware of the new care certificate introduced by Skills for Care. The Care Certificate looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

Staff told us the induction was very good. One new member of staff said, "I have a mentor and have supernumerary time to get to understand my role and responsibilities, and I have received very good training."

There was a computerised training matrix to monitor which training staff had completed and when it required updating. It showed that staff had initially completed training in essential topics and this had been followed by periodic updates. However, the matrix showed that some staff had not refreshed their training in a timely manner. The management team described to us how they were taking action to address any shortfalls.

Staff received regular supervision and support sessions. They told us it had been difficult without a manager, but they felt things were getting better at the time of our inspection. All staff said they also supported each other and worked well as a team. We also saw staff received an annual appraisal of their work performance.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who might not be able to make informed decisions on their own and protect their rights. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). DoLS is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The staff we spoke with had a good understanding and knowledge of this subject, and people who used the service had been assessed to determine if a DoLS application was required. We looked at the care files of people who had an authorised DoLS. We saw this was detailed in a care plan, which clearly described any imposed conditions and how these were being met. This ensured the person's needs were being met in the least restrictive way.

Staff were clear about their roles and responsibilities to ensure people's human rights were protected. They knew people well and were aware of their communications needs and how best to enable them to make decisions for themselves. They were also knowledgeable about the process that needed to be followed when people were unable to make certain decisions themselves. For instance, staff described how they would make sure decisions made were in people's best interest. They involved the person using their most effective means of communication, and involved relatives and relevant health professionals as required.

We observed lunchtime on Howden unit, which had a pleasant, chatty, inclusive atmosphere. There was a menu displayed, tables were set with tablecloths, cutlery, serviettes and condiments. People were given choices of food and drink. One person did not like the choices on the menu so was given a different meal of their choice, and another person requested sandwiches which were provided. We saw people were not rushed and second helpings were offered. People who required support were given this sensitively and discretely.

People we spoke with all told us the food was always very good. One person told us, "It's absolutely good." Another person said, "I am a coeliac [a disease where the person's immune system reacts negatively to gluten] and the staff are fully aware of what I can and can't eat." A third person commented, "I like a prawn salad for tea and I get this, it's very good."

Staff we spoke with were knowledgeable about people's dietary needs and were aware of special diets, people's cultural needs and if they were at risk of choking. For individuals who were at risk of choking, staff had guidelines and assessments from dieticians and speech and language therapists to follow. These were aimed at minimising the risk of them choking.

Care plans clearly detailed people's needs and how they were met. We saw evidence of involvement from health care professionals when required. For example, we saw referrals to speech and language therapists when people presented with swallowing difficulties, as well as referrals to the mental health team if people were presenting with behaviours that could challenge. The latter was aimed at identifying the best way possible to manage the behaviours in the least restrictive way.

The service was a purpose built home and had wide corridors and door opening to meet the needs of people who used a wheelchair. However, one person we spoke with told us how they felt their room did not meet their needs. They could not access their toilet or wash hand basin and had only one table that was accessible for activities. We discussed this with the operations manager who agreed to look into improving the environment for people with mobility needs.

Good

# Is the service caring?

## Our findings

People we spoke with all told us how kind, considerate, caring and thoughtful the staff were. One person living at the home said, "Nice staff." Another person told us, "It's alright here." A third person commented, "The staff are very good, they have a hard job and they are always smiling and willing to have a laugh with you." A relative told us they felt staff supported their family member very well adding, "I can't fault them."

During our visit we spent time in communal areas observing people who used the service and talking to visitors and staff. We saw staff interacted with people in a positive way. They supported people in a caring and responsive manner, while assisting them to go about their daily lives and encouraging independence. We observed staff treating each person as an individual and involving them in making decisions. We saw people were always asked what they wanted to do, or what assistance they needed, in an inclusive sensitive way. □

People's needs and preferences were recorded in their care records. Staff were able to describe the ways in which they got to know people, such as talking to them and reading their care files, which included information about people's likes, dislikes, their preferred routines and their life history.

There was a multi-cultural room which could be used to pray or for peaceful reflecting. Staff told us people could also access the community to attend churches, mosques or services of other religious denominations. Staff we spoke with were aware of people's religious and cultural beliefs and what was important to them.

People living at the home looked well-presented and cared for and we saw staff treated them with dignity. We saw staff respecting people's privacy and dignity by knocking on bedroom doors before entering, closing doors while providing personal care and speaking to people about things discreetly. Noticeboards around the home provided people with information promoting respecting people's dignity, as well as the names of the dignity champions at the home. A dignity champion is a staff member who signs up to act as a good role model to educate and inform all those working around them, in order to promote dignity in people's care.

We saw relatives could visit without restriction and were made welcome. We saw visitors freely coming and going as they wanted during our inspection. One relative told us, "I visit most days, everyone is very friendly and pleasant."

Good

# Is the service responsive?

## Our findings

People told us staff were responsive to their or their family member's needs. We saw interactions between staff and people using the service was good and focused on the individual needs and preferences of the person being supported. Care workers offered people options about their meals or which activities they wanted to participate in, and responded to their requests promptly.

Care files we looked at contained care plans that identified people's needs, setting out how to support each person so that their individual needs were met. We found the care plans on three units were well organised and easy to follow. However, on the forth unit files were very bulky, and although each person's needs had been identified it was not easy to follow or find information, due to the amount of documents in the file, some of which were duplicated.

We found care plans informed staff how to support and care for people to ensure that they received care in line with their assessed needs. They had also been regularly evaluated to ensure that they were up to date and captured any changing needs. For example, we saw people who were at risk of poor nutritional intake were monitored and their weight was checked weekly. Where people had lost weight referrals to the appropriate health care professionals had been completed. We also saw there were good records of the outcomes of these visits so staff could meet any changing needs.

The service employed two physiotherapists who are based on Ladybower unit, but worked throughout the home. There is a physiotherapy room which contained equipment to help people retain their mobility or become more mobile.

The home employed a team of five activities co-ordinators who arranged social activities and stimulation within the home and out in the community. During our tour of the home we saw there was a large dedicated activity area where a breakfast club was taking place and people were joining in various activities. The session was well attended and people were clearly enjoying themselves. Activities also took place on the different units, for people who were unable to go to the activity area. For instance, we saw a group of eight people taking part in a quiz.

People we spoke with told us the activities were very good. One person told us, "Get lots of activities and things to do, there is always something going on." Another person said, "We get to go out, I like going to the pictures." A relative we spoke with told us their family member was "Not bothered about activities" but added that they liked to play their music and watch football. They also told us their family member had enjoyed a trip to Blackpool. The activity board highlighted planned activities which include a pub lunch, a shopping trip and newspaper reading.

The activity team leader told us they consulted with people to see what they liked to do and read their care plan to find out about past interests. They said there was also one to one activities provided for people who did not join in the group activities, to ensure people were not isolated. They described how they spent one to one time with people reading or talking with them, as well as organising group activities. They said

household jobs had also been added to the activity programme, such as folding laundry, which they said people enjoyed. We also saw there was a sensory room which staff said people liked to use to relax.

The provider had a complaints and compliments procedure which was available to people who lived at and visited the home. Records showed that the service had fully investigated complaints and concerns raised. We saw 'See, Hear, Speak' posters around the home, encouraging people to speak up if they witnessed anything that concerned them. There was also a box in reception for people to post their opinions of the service provision or raise concerns.

The people we spoke raised no concerns, but told us they would speak to staff if they had any concerns. A relative told us they had been visiting the home for a number of years and had never made a formal complaint. However, they added that when a minor concern regarding their family member's laundry had been raised, immediate action had been taken to rectify the issue.

Requires Improvement

# Is the service well-led?

## Our findings

At the time of our inspection the service did not have a manager in post who was registered with the Care Quality Commission.

In the absence of a manager the newly appointed deputy manager was overseeing the day to day running of the home, supported by two senior company managers. The staffing structure also included a clinical nurse manager [CNM] who was new in post, unit managers, teams of nurses and care workers, administration and ancillary staff. There was also an on call system in place for senior staff to provide additional advice and assistance should it be necessary. A second CNM was due to commence in November.

Staff told us there had been a lack in consistently in the management of the home over recent months, which had led to a lack of communication. They felt this had impacted on consistency across all the units. However, they said things had improved recently and they were more positive about the future. Staff told us they felt they worked well as a team and supported each other.

We asked the operations manager what they were prioritising at the home. They told us they wanted to work on defining staff roles more, for instance the deputy and clinical nurse manager roles, and complete the redecoration programme. The latter included the remodelling and refurbishment of the unit not in use at the time of the inspection.

There were systems in place to monitor and improve the quality of the service provided and check company polices were being followed. This included regular audits of areas such as the environment, infection control, fire safety, medication and care plans. We saw members of the company quality team had also carried out checks to make sure the home was operating efficiently. Where shortfalls had been identified action plans had been put in place and monitored. However, the shortfalls we found during this inspection, such as omissions from rotas and medication discrepancies had not been identified and addressed in a timely manner.

Following the inspection we were provided with evidence to show further checks had taken place and areas in need of improvement were being addressed. For instance, plans were being introduced to make sure all units had consistent care files and medication was recorded robustly on all units. They also told us a medication review had taken place for one person to ensure they were prescribed the correct medication. However, improvements made needed to be embedded into practice.

The people we spoke with said they were happy with the care provided and how the home was run. A relative spoke highly of the care provision and how the home operated adding, "I love this place [Willowbeck]."

The provider gained people's opinions in a number of ways. For instance, the person in charge had completed a daily walk around the home to talk to people and assess how things were operating. We saw a suggestion box was available in the reception area for people to post their opinions or queries. This included

'How are we doing' cards, which some people had completed with positive comments about Willowbeck. In addition, we saw the records of meetings attended by the management team to gather people's views and discuss any planned changes. We also saw that other meetings had been arranged for the near future.

The provider had also used questionnaires to gain the views of people using the service, relatives and visiting professionals. We saw people had responded to the set questions in a positive way. The outcome of the surveys were available in the reception area, however we noted they were not in a format that some people using the service could understand. This was discussed with the operations manager so they could consider alternate ways to display the information.

We saw company policies and procedures were in place to inform and guide people using the service and staff. They had been reviewed and updated regularly to make sure they reflected current practice.