

Titleworth Neuro Limited

Willow Grange Care Limited

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

This was an unannounced comprehensive inspection which took place on 29 August and 4 September 2018.

People living at Willow Grange (formerly known as Coombe Hill and Blenheim Lodge Nursing home) receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The care home can accommodate up to 44 people living across three floors in one adapted building. Most people living in the home were older people living with dementia and/or who had nursing needs. The service also specialises in supporting people with mental ill health problems, learning disabilities or autistic spectrum disorders, acquired brain injuries or sensory loss. At the time of our inspection 37 people resided at Willow Grange.

The service continues to have the same registered manager who has been in post since 2016. A registered manager is a person who has registered with the CQC. Registered managers like registered providers 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.

At the last inspection, which we carried out in April 2017, we rated the service 'Requires Improvement' overall and for the three key questions, 'Is the service effective, caring and well-led?' This was because we found staff did not always given sufficient opportunities by their managers to reflect on their working practices and develop their knowledge and skills, some staff did not always respect people's privacy and governance systems were not always effective.

At this comprehensive inspection, we found the provider had taken appropriate steps to address the issues we identified at their last inspection. This included ensuring care staff were now suitably trained and supported, staff always respected people's privacy and more effective management oversight and scrutiny arrangements were established to help monitor the quality and safety of the service people received. This included the appointment of new clinical nurse lead and an independent care consultant and the introduction of a new electronic care planning system.

However, we also identified a number of new issues at this inspection where the provider still needed to take further action to improve and meet the essential standards and regulations. The service has therefore been rated 'Requires Improvement' overall for the third consecutive time and for all five key questions.

This was because we found some staff did not always ensure people were treated with kindness and respect. Although we saw most staff interacted with people in a kind and compassionate manner, we observed several instances of poor practice including one incident when a member of staff used inappropriate language and gestures to 'encourage' an individual to eat their lunch and other staff not

engaging well with the people they were assisting to have their lunch.

Furthermore, people did not always receive care and support which met their individual needs and reflected their preferences. Half the relatives we spoke with expressed being concerned that staff did not always follow their family members wishes or guidance in their care plan. Examples given included several incidents of people's family members being left in bed too long or being assisted to go to bed too early by staff contrary to guidance in their care plan about their preferred daily routines.

These shortfalls represent two breaches of the HSCA (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The home was adequately staffed on both days of our inspection. However, it was evident from most of the comments we received from people living in the home, their relatives and staff we spoke with that they felt there were sometimes issues with the way staff were deployed in the care home. We discussed this issue with the registered manager at the time of our inspection who told us they had recently reviewed current staffing levels and were in the process of recruiting new staff to increase the number of staff that were on duty at night. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

In addition, although care staff were suitably trained to effectively carry out their roles and responsibilities; we found not all nursing staff had completed the specialist training they needed to effectively meet peoples more complex health care needs and use specialist medical equipment safely. We discussed this issue with the registered manager who showed us a time specific action plan they had developed to ensure all nursing staff completed up to date training in the safe use of syringe drivers, Percutaneous Endoscopic Gastrostomy (PEG) feeding tubes, catheters and pressure sore care within the next three months.

People also did not always have sufficient opportunities to participate in meaningful activities that reflected their social interests. We recommended the provider seek advice and guidance from a reputable source, about developing a programme of social activities that met the needs and social interests of people living with dementia.

Finally, although we found the provider had made some progress to improve their governance systems, further improvements were still required because of the number of new issues described above that we identified during this inspection.

These negative comments notwithstanding, we found the provider continued to have robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse and neglect. Appropriate recruitment checks took place before staff were permitted to commence working at the home. The environment was kept hygienically clean and safe. People received their medicines as prescribed.

People were supported to eat and drink enough to meet their dietary needs and preferences. Managers were aware of their duties under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent before providing any care and support and followed legal requirements when people did not have the capacity to do so. They also received the support they needed to stay healthy and to access health care services.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. When people were nearing the end of their life, they received compassionate

and supportive care.

People had new electronic personalised care plan, which set out how their care and support needs should be met by staff. The provider had suitable arrangements in place to appropriately deal with people's concerns and complaints.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Some aspects of the service have deteriorated and are no longer safe. Consequently, the rating for this key question has been downgraded from 'Good' to 'Requires improvement'.

This was because there were not always enough staff suitably deployed in the care home to meet people's needs and wishes.

Procedures continued to be in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

The provider had assessments and management plans in place to minimise possible risks to people, this included infection control and food handling measures.

The home remained clean and free from odours, and was appropriately maintained.

Robust recruitment processes helped to ensure that staff were suitable to work at the service.

Medicines were managed safely and people received them as prescribed.

Requires Improvement ●

Is the service effective?

The service had made improvements since their last inspection, but some aspects are not effective. Therefore, the rating for this key question remains 'Requires Improvement'.

The training and support care staff received had significant improved in the last 12 months, but most nursing staff did not have all the right knowledge and skills they needed to effectively perform their specialist health care roles and responsibilities.

People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access health care services.

The registered manager and staff were knowledgeable about and adhered to the Mental Capacity Act 2005 and the Deprivation

Requires Improvement ●

of Liberty Safeguards.

Is the service caring?

The service had improved since their last inspection, but some aspects are not caring. Therefore, the rating for this key question remains 'Requires Improvement'.

This was because we found some staff did not always ensure people were treated with kindness and respect.

People were supported to do as much as they could and wanted to do for themselves to retain control and independence over their lives.

Requires Improvement ●

Is the service responsive?

Some aspects of the service have deteriorated and are no longer responsive. Therefore, the rating for this key question has been downgraded to 'Requires Improvement'.

This was because people did not always receive care and support which met their individual needs and reflected their preferences.

In addition, people living with dementia or who were bed-bound did not have sufficient opportunities to participate in meaningful activities that reflected their social interests.

The provider was in the process of introducing a new electronic care planning system to help staff access all the information they needed to know about how to meet people's care needs and wishes more easily.

The provider had arrangements in place to deal with people's concerns and complaints in an appropriate way.

Requires Improvement ●

Is the service well-led?

The service has made some improvement since their last inspection, but some aspects continue not to be well-managed. Therefore, the rating for this key question remains 'Requires Improvement'.

Although we found the provider had improved the way they monitored the quality of service delivery; these systems remain relatively new and will need time to bed-in. We also identified many new issues during this inspection, which the new governance systems had failed to pick up.

Requires Improvement ●

The service continues to have a registered manager in post.

The provider routinely gathered feedback from people living in the care home and their relatives.

Willow Grange 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 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.

This inspection was prompted in part because of information we received from the local authority of the Royal Borough of Kingston-upon-Thames who were concerned about the quality and safety of the care and support people living at Willow Grange were receiving. In response to these concerns the provider has been working closely with the local authority and in August 2018 voluntarily agreed to self-impose an embargo on the service accepting any new admissions to the care home until further notice. The information shared with the CQC indicated potential concerns about the way this care home was being managed.

The inspection was conducted over two days on 29 August and 4 September 2018. The first day of our inspection was unannounced and we told the provider we would be returning on the second day. The inspection team on the first day consisted of a lead inspector, a specialist advisor who was a registered nurse and an expert-by-experience. The expert-by-experience had personal experience of caring for someone who lived with dementia. Only the lead inspector returned to the service on the second day.

Before the inspection, we reviewed all the information we held about this service. This included previous inspection reports and notifications the provider is required by law to send us about events that happen within the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke in-person with seven people who lived at the home, eight visiting relatives/friends, an independent care consultant and a local authority placement reviewing officer. We also talked with various managers and staff who worked for the provider including, the registered manager, the area manager, two registered nurses, six health care workers, an activities coordinator, two cooks and the maintenance person. In addition, we received written feedback about the service from two relatives and a local authority commissioning officer.

Throughout our inspection we observed the way staff interacted with people living in the home and performed their roles and responsibilities. We also used the Short Observational Framework for Inspection (SOFI) to observe lunchtime meals being served throughout the home on both days of our inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Records we looked at included ten people's care plans, five staff files and a range of other documents that related to the overall management of the service.

Is the service safe?

Our findings

The home was adequately staffed on both days of our inspection. However, we received mixed comments from people living at the home and relatives we spoke with about staffing levels in the home, and the way staff were deployed throughout the building. Typical feedback included, "Most of the staff are amazing, but I do wish they [staff] had more time to sit and talk with us", "There isn't always enough staff on duty. My [family member] had to wait in bed till 11.30am the other day until a member of staff was free to come and help her get up", "I think the staff are put under a great deal of pressure because they're often very short staffed here, especially at weekends. There wasn't enough staff around to take my [family member] to the toilet on time the other day."

Several staff also remarked that they enjoyed working at Willow Grange, but felt stretched at times because they were often short staffed. Typical comments we received included, "We're short staff most of the time", "It's not unusual for us to be two staff down" and "We rarely have any time to spend just sitting and talking with the residents because we're so busy meeting their basic care needs. We definitely need more staff on duty."

During our inspection we also observed a member of staff who appeared to be in a rush fail to ensure both footplates were in place on a wheelchair they were using to help transfer a person from their bedroom to a communal area. This resulted in the loose footplate hitting the bedroom doorframe and making everyone in the vicinity jump. The member of staff acknowledged their mistake, immediately apologised to the person they were supporting, and told us, "It can be very busy here in the morning and you do feel under pressure to get things done quickly. It's hard because we've got so many people to look after."

We discussed these issues with the registered manager who told us they had recently reviewed current staffing levels and were in the process of recruiting new staff to increase the number of staff that were on duty at night. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

The provider continued to have suitable arrangements in place to deal with foreseeable emergencies. Records showed the service had developed a range of contingency and business plans to help staff deal with such events quickly. We saw fire exit signage conspicuously displayed on doors and walls throughout the premises and fire evacuation ski-pads were available in stairwells to help people with physical disabilities navigate the stairs. People's care plans contained a personal emergency evacuation plan (PEEP), which explained the help people would need to safely evacuate the building in an emergency. Records showed staff routinely participated in fire evacuation drills at the home and received on-going fire safety training. Staff demonstrated a good understanding of their fire safety roles and responsibilities.

However, we found the fire-resistant laundry room door had been unsafely propped open, despite the London Fire and Emergency Planning Authority (LFEPA) identifying this as a fire safety risk in a recent inspection they carried out at the home. We discussed this issue with the registered manager who arranged for the automatic fire door release mechanism attached to the laundry room door to be repaired by the

second day of our inspection. This meant this fire-resistant door could now be kept open when the laundry was in use, but would automatically close in the event of the fire alarm being activated.

The environment was well-maintained, which contributed to people's safety. Maintenance records showed environmental health and safety, and equipment checks were routinely undertaken by suitably qualified professionals in accordance with the manufacturers' guidelines. This included checks in relation to the service's gas safety and electrical installations, portable electrical appliances; fire equipment, including fire extinguishers, fire alarms; heating and ventilation systems; water hygiene and monitoring of water temperatures; passenger lifts; and, the routine servicing of mobility aids and call bells. We also saw radiators were suitably covered throughout the home.

The provider had robust systems in place to identify report and act on signs or allegations of abuse or neglect. Staff had received up to date safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take immediately to report its occurrence. One member of staff told us, "I've had my safeguarding training which has given me the skills to recognise when people may be unsafe."

We looked at documentation where safeguarding alerts had been raised in respect of people living in the home and saw the new provider had taken appropriate steps, which they followed up to ensure similar incidents were mitigated. The registered manager told us they were working with the Royal Borough of Kingston-Upon-Thames to manage these incidents and minimise the risk of similar events reoccurring. We noted that the provider is working closely with the local authority and voluntarily imposed an embargo on any new admissions to Willow Grange until further notice while any outstanding safeguarding incidents continued to be investigated.

Measures were in place to reduce identified risks to people's health, safety and welfare. People's care plans included detailed risk management plans for staff to follow, which were routinely reviewed and updated. This guidance for staff included how to prevent and/or manage people identified as being at risk of falling, malnutrition and dehydration, choking and developing pressure sores, for example. It was clear from discussions we had with staff and working practices we observed staff understood the risks specific individuals might face and what action they needed to take to prevent or mitigate them. For example, throughout our inspection we saw several instances of two staff using mobile hoists appropriately to transfer people safely from an armchair to a wheelchair. Several staff confirmed they received lifting and manual handling training, which was refreshed annually. One staff member said, "I always transfer people with the help of another member of staff and I have been trained how to move and transfer people safely."

The provider's staff recruitment procedures continued to be robust. Records indicated when an individual applied to become a member of staff, the provider carried out thorough checks around their suitability to work in adult social care. This included looking at their right to work in the UK, employment history, previous work experience, employment and character references and criminal records. Personal identification numbers for all nurses employed to work the home were also checked to confirm they were registered with the Nursing and Midwifery Council (NMC) and therefore authorised to practice as nurses. The registered manager told us it was custom and practice for the provider to carry out criminal records checks at three yearly intervals on all existing staff.

People continued to be protected by the prevention and control of infection. People told us the home usually looked and smelt clean, which we saw was the case throughout our two-day inspection. We observed staff using appropriate personal protective equipment. For example, we saw staff always wore disposable gloves and aprons when providing personal care to people and there was always soap and

paper towels in the toilets. Records indicated all staff had received up to date infection control training and there were clear policies and procedures in place. Staff were knowledgeable about what practices to follow to prevent and control the spread of infection.

Appropriate systems were in place to minimise any risks to people's health during food preparation. We saw the kitchen was kept hygienically clean, and catering staff used colour coded chopping boards when preparing different food groups and checked fridge and freezer temperatures daily. The home had recently been awarded the second highest food hygiene rating of 4 stars by the food standards agency. Records indicated all staff had completed basic food hygiene training.

Medicines were managed safely. People told us they had confidence in the staff who supported them to take their prescribed medicines on time. We saw medicines were securely stored in locked medicines trolleys and/or cupboards kept in lockable rooms. People's care plans contained detailed information about their prescribed medicines and how they needed and preferred them to be administered. We saw medicines administration records (MARs) were appropriately maintained by staff authorised to handle medicines in the home. There were no gaps or omissions on MAR charts. Checks of medicines stocks and balances, indicated people received their medicines as prescribed.

Is the service effective?

Our findings

At our last inspection, we found staff were not always suitably trained to effectively carry out their roles and responsibilities. At this inspection records indicated that action had been taken to improve the training care staff received. There was a rolling programme of training in place which ensured staff's knowledge and skills remained up-to-date and reflected current best practice. In addition, all new staff were required to complete a thorough induction and shadow experienced members of staff before being approved to support people unsupervised.

However, the improvements described above notwithstanding, we found not all nursing staff had completed the specialist training they needed to effectively meet people's more complex health care needs. For example, most nursing staff had not received any or up to date training in the safe use of syringe drivers, percutaneous endoscopic gastrostomy (PEG) feeding tubes and catheters, which some people living in the home used. In addition, insufficient numbers of nursing staff had also not received up to date prevention and management of pressure sore training. A syringe driver is a medical device used to administer a continuous infusion of drugs and PEG feeding is an endoscopic medical procedure in which a tube is passed into a person's stomach.

We discussed this issue with the registered manager who was aware there were gaps in the training some nursing staff had completed. The registered manager showed us a time specific action plan they had developed to ensure all nursing staff completed up to date training in the safe use of syringe drivers, PEG feeding tubes, catheters and pressure sore care within the next three months. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

Staff continued to have sufficient opportunities to review and develop their working practices. We saw the provider operated a rolling programme of regular supervision (one-to-one meetings) and annual appraisals where staff were encouraged to reflect on their work practices and identify their training needs. Records indicated staff at all levels routinely attended individual meetings with their line manager and group meetings with their co-workers. Staff told us they were encouraged to talk about any work-related issues and training needs they might have at these meetings.

People were supported to have enough to eat and drink. People's care plans included detailed nutritional assessments which informed staff about people's food and drink preferences and any risks associated with them eating and drinking. Staff monitored the food and drink intake of people who had been assessed as being at risk of malnutrition or dehydration to ensure these individuals continued to eat and drink adequate amounts. Cooks were aware of people's individual dietary needs and able to cater for people with food allergies or special diets due to their health care needs.

People also said they enjoyed the meals they were offered at the care home and typically described the choice of meals as being 'good'. One person told us, "The puddings are very good", while another remarked, "There's always a choice." We saw staff routinely offered people drinks during and outside of mealtimes.

We saw the catering staff prepared a range of meals at lunchtime on both days of our inspection. However, although most of these meals looked and smelt appetising, we found the pureed dishes prepared for people on a soft diet did not look that well-presented when served on a plate. We saw that people who were served the pureed meals at lunchtime on the first day of our inspection were presented with a plate of food that consisted of a single mass of monochrome food that did not look very appetising.

We discussed this issue with the registered manager who told us the presentation of pureed food had been identified by the service's independent care consultant as something they needed to improve upon, which they were in the process of addressing. The registered manager spoke with the agency cook on duty on the first day of our inspection to remind them to always use food moulds to different food groups separate on the plate and improve the presentation of the pureed meals. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

People continued to be supported to maintain their health and well-being. People's care plans set out how staff should be meeting their specific health care needs. Staff carried out regular health checks and maintained daily records of the support people received, including their observations about people's general health. The provider ensured people attended regular health care check-ups with a range of community health care professionals, including GP's, tissue viability nurses, occupational therapists, dentists, opticians and chiropodists. Staff maintained appropriate records of these health care appointments.

The premises were kept free of obstacles and hazards which enabled people to move safely and freely around their home. People and their relatives told us the home was a "comfortable" place to live. We saw easy to understand pictorial signage was used throughout the care home to help people orientate and to identify important rooms or areas such as their bedroom, bathrooms and toilets and communal lounge and dining areas.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw appropriate arrangements were in place to ensure people consented to their care and support before this was provided. Care plans showed people's capacity to make decisions about specific aspects of their care was assessed. This gave staff the information they needed to understand people's ability to consent to the care and support they received. Managers had identified that some people required their liberty to be deprived to keep them safe and free from harm. We saw the service had applied to the local authority for authorisation to deprive people of their liberty and maintained records about the restrictions in place and when the authorisations were due to be reviewed.

Is the service caring?

Our findings

At our last inspection we found some staff did not always respect people's privacy. For example, several people living at the care home and their relatives told us staff did not always knock on bedroom doors and ask people's permission to enter, which we observed happen at their previous inspection.

At this inspection we saw staff did respect people's privacy. People told us staff knocked on their bedroom door and always asked their permission to enter before doing so. We observed numerous instances of staff doing this throughout our inspection. In addition, we saw staff ensure toilet, bathroom and bedroom doors were kept closed when they were supporting people with their personal care and address people by their preferred name. Several staff told us they had been reminded about roles and responsibilities to always respect people's privacy and dignity, which the registered manager had agreed to do at the time of our last inspection.

However, the improvements described above notwithstanding, some staff did not always ensure people were treated with kindness and respect. We received mixed comments from people living in the home and their relatives about the care provided by some staff. Typical feedback included, "Most of the carers are bubbly and happy, and seem to genuinely enjoy their work, but I have witnessed a few staff be quite brash to residents at times", "Some of the staff interact well with the residents and show a lot of understanding and compassion, but others lack that personal touch" and "One or two [staff] can be a bit 'grumpy'."

Throughout our two-day inspection we observed most staff interacted with people living in the home in a kind and compassionate manner. For example, we saw numerous instances of staff communicate with people in a warm and friendly way. However, we also witnessed a member of staff speak abruptly to a person who was eating their lunch and inform them, "I'm watching you", while using a two-fingered gesture to point at both their own and the service user's eyes to emphasise what they had said. The language, tone and hand gesture used were wholly inappropriate and this incident was discussed with the registered manager at the time of our inspection.

In addition, although we saw staff assisting people to eat their meals in a mainly dignified manner, which they achieved by sitting down next to people; most staff undertook this task in silence, with very little interaction taking place with the people they were supporting to eat their meal. For example, during lunch on both days of our inspecting we saw several staff say nothing to the people they were assisting to eat their meal about what they were doing or what was on their plate.

These shortfalls represent a breach of regulation 10 of the HSCA (Regulated Activities) Regulations 2014.

Staff communicated with people in appropriate and accessible ways. People's care plans contained information about their personal communication styles and preferences and how individuals made choices and decisions about the care and support they received. People's communication needs and preferences were well known by staff. This was evidenced through our conversations with staff who could explain how each person communicated and made choices about what they wanted. The registered manager told us the

staff team could speak a range of different languages, which meant a few staff could always communicate with people whose first language was not English.

People were given essential information about the service. We saw a range of easy to understand pictorial signage and photographs conspicuously displayed throughout the home to help people identify rooms and areas that would be important to them, up and coming social events and activities, and profiles of staff who worked at the home.

Relatives and friends could visit without being unnecessarily restricted. Visitors told us they were not aware of any restrictions on times they could visit their family member, friend or client. Managers and staff told us people's guests were encouraged to have a sit-down meal with their family member or friend, as well as celebrate special days, such as birthdays and anniversaries.

Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. People told us religious leaders representing various denominations of the Christian faith regularly visited the home and they sometimes attended religious services at various local churches. Information about people's spiritual needs and ethnicity was included in their care plan. The head cook demonstrated a good understanding of the wide range of cultural, ethical and religious dietary needs and wishes of people living in the home, which was reflected in the weekly menus and the meals served each day. For example, the head cook knew which people living in the home only ate Halal meat permissible under Islamic dietary law or had a meat free diet because they were practising Muslims.

The provider had up to date equality and diversity policies and procedures in place which made it clear how they expected staff to uphold people's rights and ensure their diverse needs were respected. Records indicated staff had received equality and diversity awareness training.

Staff encouraged people to be as independent as they wanted and could be, although most people living in the home were dependent on the care and support they received from staff with day-to-day activities and tasks. For example, staff were able explain to us what aspects of their care people needed support with, such as moving and transferring or assistance at mealtimes, and what people could do independently. Throughout the home we saw handrails and a passenger lift that enabled people to move freely around the care home.

Is the service responsive?

Our findings

People did not always receive care and support which met their individual needs and reflected their preferences. We received mixed comments from people living in the home and relatives about how person centred the care provided at Willow Grange was. Half the visit relatives/friends we spoke with said they were impressed with the staff who knew exactly what their family members/friends needed and what their preferences were, while the rest expressed concern that staff did not always follow their family members wishes or guidance in their care plan. Two relatives gave us several examples of incidents when their family members had been left in bed too long in the morning or assisted to go to bed too early in the evening. One relative explained how that contrary to their family members care plan guidance about their daily routines they had been left in bed until lunchtime the other day, which had resulted in them missing their breakfast. This relative told us, "My [family member] was very upset at what had happened to them and could not understand why they were left in bed for so long."

This is a breach of regulation 9 of the HSCA (Regulated Activities) Regulations 2014.

This breach notwithstanding, we saw the provider was in the process of introducing a new electronic care planning system which enabled staff to access all the information they needed to know about how to meet peoples care needs and wishes more easily on portable hand-held devices. The new electronic care plans were written in a person-centred way and contained detailed information about each person's specific needs, abilities, likes and dislikes, life history, and people and places that were important to them. They also included information about how people preferred staff to deliver their personal care. For example, people's daily routine set out for staff when people liked to wake up, how they wished to be supported with getting washed and dressed and when and where they would like to eat their meals. This gave staff good information about what was important to people so that they could tailor support to meet people's individual needs and wishes. How the new electronic care plans work in practice will be assessed at the services next inspection.

The service did not always support people to take part in meaningful social activities. We received mixed comments from people living in the home and their relatives about the lack of opportunities they or their family members had to choose to participate in meaningful social activities at Willow Grange. A few relatives expressed being concerned their family could become socially isolated. Typical feedback included, "There is a problem with activities because the activities coordinator, who is very good by the way, often gets occupied with one or two people, so other people miss out", "The outside entertainers who come into the home have been excellent and the residents have all had a lovely time, but in the main I feel my [family member] is under stimulated due to a lack of suitable in-house activities they could join in with" and "The days out for the residents have been well-organised, but it's just a shame these are few and far between and only a handful of residents get to go. Most residents are normally stuck in one main communal room with nothing to do."

On the second day inspection we saw some staff, including an activities coordinator initiate a few activities in the main communal lounge. An activities coordinator gave us several good examples of activities they had

introduced, which included gentle exercise classes, bingo, skittles, gardening, reminiscence groups, film presentations, and meals out at a local pub.

However, on the first day of our inspection we observed a large group of people spend their day just sitting in the main communal lounge not engaged in any meaningful activities. We saw the television remained on throughout the day, which very few people appeared to be watching the daytime programmes that were showing. A relative told us, "I have raised my concerns with staff that my [family member] was spending uncomfortably long periods of time just sitting in the lounge not doing much." We also saw very little in the way of appropriate stimulation offered to people living with dementia and/or who were bed-bound. It was unclear from comments we received from staff what opportunities people had to engage in dementia friendly social activities with staff either in the main communal areas or in their bedroom in order to mitigate the risk of these individuals becoming socially isolated.

We discussed this issue with the registered manager who agreed people living with dementia and/or individuals who were bed-bound in the home would benefit from having greater opportunities to take part in more structured dementia friendly social activities. We recommend the service seek advice and guidance from a reputable source, about developing a more structured and dementia friendly programme of social activities which is based on the interests of people living in the home.

Peoples care plans continued to be regularly reviewed and updated as and when required if there had been changes to a person's needs and/or circumstances. Where changes were identified, people's care plans were updated quickly and information about this was shared with staff through shift handovers and meetings.

When people were nearing the end of their life, they received compassionate and supportive care at the home. People's preferences and choices for their end of life care were clearly recorded in their care plan and acted upon. We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) forms in care plans for people who had made this decision. Managers told us they worked closely with GPs and palliative care professionals from a local hospice.

However, records showed that most staff had not completed up to date end of life care training. Several members of staff told us they had completed most of their mandatory training, but had yet to attend an end of life care course. We discussed this training issue with the registered manager who agreed all staff should receive end of life care training as it was relevant to all staff's roles and responsibilities.

The provider had suitable arrangements in place to respond to people's concerns and formal complaints. Most people living in the home and their visiting relatives or friends said they knew how to make a complaint if they were unhappy with the standard of care and support provided at the home. People confirmed they had been given or seen a copy of the 'Service Users' guide, which contained the new providers complaints procedure. A process was in place for managers to log and investigate any complaints received, which included recording any actions taken to resolve any issues that had been raised.

Is the service well-led?

Our findings

At our last inspection we found the management oversight and scrutiny of the service was not always operated effectively.

At this inspection we found the provider had taken steps to improve their quality monitoring systems. This included the use of an independent care consultant who in the last 12 months had carried out a number of audits of the service and made recommendations in relation to how they might improve the standard of care and support they provided people. We saw an action plan had been developed based on their independent care consultant's findings which the provider was in the process of implementing. The service had also recently recruited a suitably qualified and experienced clinical lead nurse whose responsibilities would include management oversight and scrutiny of the home's nursing staff and their medical practices. The new clinical lead nurse told us they would be holding regular individual and group supervision meetings with all the nursing staff and carrying out routine spot checks and audits of their medicines handling practices and use of specialist medical equipment in the home. The registered manager was also confident the new electronic care planning system the provider had recently introduced would make it easier for managers and senior staff to closely monitor staff record-keeping and care practices.

In addition, we saw managers and senior staff continued to be responsible for undertaking regular audits and spot checks at the care home. For example, the area manager continued to routinely visit the home and carry out themed audits that focused on a different aspect of service delivery, while the registered manager and her senior staff still carried out routine checks on care plans and risk assessments, infection control and food hygiene, fire safety, complaints and safeguarding incidents and accidents.

However, all the improvements highlighted above notwithstanding, these systems were still relatively new and had failed to pick up or the provider respond quickly enough to a number of issues we identified during this inspection. This included a culture where some staff did not always treat people with kindness and respect, staff feeling over stretched at times because of the way they were sometimes deployed throughout the care home, nursing staff not always being adequately trained to effectively perform all their medical roles and responsibilities, insufficient opportunities for people to engage in meaningful social activities, fire safety regulations not always being followed and pureed meals not always being presented in an appetising way.

We discussed the governance issues with the registered manager who told us with the support of the new clinical nurse lead and independent care consultant and the introduction of the new electronic care planning system, they were confident they had the right personnel and systems in place to reflect on their working practices and continue learning lessons to improve. Progress made by the provider to achieve this stated aim will be assessed at their next inspection.

The registered manager demonstrated a good understanding of their role and responsibilities regarding meeting CQC registration requirements and for submitting statutory notifications of incidents to us. This was important as we needed to check that the provider took appropriate action to ensure people's safety and

welfare in these instances.

The provider promoted a culture within the service that was open, supportive and willing to make changes when needed to improve the quality of support provided to people. People, their relatives and professional representatives were all encouraged to share their experiences and views about the quality of the service provided at the care home through regular individual and group meetings, telephone contact and satisfaction surveys.

The provider valued and listened to the views of staff working in the home. Staff attended regular team meetings where they could contribute their ideas to improve the home. Records of these meetings indicated discussions routinely took place which kept staff up to date about people's changing care and support needs.

The provider continued to work closely with various local authorities and community health and social care professionals. The registered manager told us they frequently discussed people's changing needs, reviewed joint working arrangements and shared best practice ideas with a range of community health and social care professionals who frequently visited the care home. This included local GPs, tissue viability and palliative care nurses, social workers, dietitians and occupational and speech and language therapists.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>People living in the home were not always provided with person-centred care and support by staff, which was appropriate, met their needs, and reflected their preferences. Regulation 9(1)(a)(b)(c)</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 10 HSCA RA Regulations 2014 Dignity and respect</p> <p>The provider did not ensure staff always treated people living in the care home with dignity and respect. Regulation 10(1)</p>