Embrace Wellcare (I) Limited

Willow Gardens

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 May 2016 and was unannounced.

Willow Gardens is a residential care home in the Bootle area of Liverpool. The service offers care and support for up to 46 people. The property offers accommodation over two floors with lift access. The upper floor is equipped to support adults with disabilities. The ground floor provides accommodation for older people. Car parking is available at the front of the building. There are gardens to the rear and side of the building.

During the inspection there were 42 people living in the home.

A registered manager was in post. 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.

People we spoke with told us they felt safe living in Willow Gardens. Staff were knowledgeable regarding safeguarding procedures and how to raise concerns. We found that appropriate safeguarding referrals had been made. We looked at how the home was staffed and found that there were sufficient numbers of staff on duty during the inspection.

We found that effective processes were in place to recruit staff and ensure they were suitable to work with vulnerable people.

We found that medicines were not always stored securely and there were some gaps in the recording of administered medicines. A medicine policy was in place and staff had completed medicine training.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. Care plans included personal emergency evacuation plans (PEEPs), which provided information to staff on how to support the person to safety in the event of an emergency, but did not advise how people would be supported to fully evacuate the home should this be necessary.

We found that accidents were recorded appropriately. Internal and external checks were made to ensure the environment and equipment remained safe.

Staff sought people's consent before providing support and care records reflected this. When people were unable to provide consent, mental capacity assessments were completed. No Deprivation of Liberty Safeguards authorisations were in place at the time of the inspection.

Staff were supported in their role through induction, supervisions and appraisal and staff told us they were well supported. Training was available to staff and records showed that courses the service considered mandatory had been completed by all staff. People told us they felt staff were well trained.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. People told us the staff supported them to access the GP and escorted them to hospital appointments when needed.

People told us they enjoyed the meals prepared for them and that they had choice. The registered manager arranged taster sessions to enable people to make try foods and decide whether they should be included within the menu. Records we viewed showed that people were regularly asked for their feedback regarding meals.

People living at the home told us staff were kind and caring and treated them with respect and that their dignity and privacy was maintained. Interactions between staff and people living in the home were warm and genuine.

Care files were stored securely in order to maintain people's confidentiality.

People we spoke with told us they had been involved in care planning, though records we looked at did not all reflect this involvement clearly. Relatives told us they had been involved in creating personal profiles for their family members and records showed people were involved in decisions regarding the home, such as decoration and menu choices.

We observed relatives visiting during the inspection. For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access.

Care plans were reviewed and were updated when people's needs changed. Care plans were detailed and informative and focused on the needs and preferences of the individual. Care plans provided staff with specific information to enable them to support people safely.

People had access to call bells in their rooms to enable them to call for staff support when required. People told us that staff responded to their call bells in a timely way.

Activities were available to people, including trips out, holidays, bingo, films and coffee mornings.

There were processes in place to gather feedback from people and listen to their views, including quality assurance questionnaires, a suggestion box and resident and relative meetings.

People had access to a complaints procedure and this was displayed within the home. The registered manager told us they had an open door policy and all people we spoke with agreed.

The home had a registered manager in post and feedback regarding the management of the home was positive. Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

Staff meetings took place every few months and staff we spoke with told us they were able to raise any issues and were confident they would be listened to.

We found that effective systems were in place to monitor the quality and safety of the service and help ensure the provider had an oversight of the home.

The manager had notified the Care Quality Commission (CQC) of most events and incidents that occurred in the home in accordance with our statutory notifications.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always stored securely and there were some gaps in the recording of administered medicines. A medicine policy was in place and staff had completed medicine training.

Risk assessments had been completed to assess and monitor people's health and safety. However personal emergency evacuation plans (PEEPs) did not advise how people would be supported to fully evacuate the home should this be necessary.

People we spoke with told us they felt safe living in the home. There were sufficient numbers of staff on duty and staff were aware of safeguarding procedures.

Safe recruitment practices were followed. Procedures were in place to ensure on-going monitoring of nurses' registration.

Accidents were recorded appropriately. Arrangements were in place for checking the environment to ensure it was safe.

Is the service effective?

Good

The service was effective.

Consent to care was gained in line with the principles of the MCA 2005.

Staff were supported in their role through induction, supervisions and appraisal and received regular training.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

People told us they enjoyed the meals prepared for them and that they had choice.

Is the service caring?

Good

The service was caring.

People living at the home told us staff were kind and caring and treated them with respect and that their dignity and privacy was maintained.

Interactions between staff and people living in the home were warm and genuine.

Care files were stored securely in order to maintain people's confidentiality.

People we spoke with had been involved in care planning and relatives told us they had been involved in creating personal profiles for their family members.

Records showed people were involved in decisions regarding the home, such as decoration and menu choices.

We observed relatives visiting during the inspection and relatives told us they were always made welcome in the home.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and informative and focused on the needs and preferences of the individual. They were reviewed regularly and had been updated when people's needs had changed.

People had access to call bells in their rooms and told us that staff responded to their call bells in a timely way.

Activities were available to people, including trips out, holidays, bingo, films and coffee mornings.

There were processes in place to gather feedback from people and listen to their views.

People had access to a complaints procedure and this was displayed within the home.

Is the service well-led?

Good

The service was well-led.

The home had a registered manager in post and feedback regarding the management of the home was positive.

Staff were aware of the home's whistle blowing policy and told

us they would not hesitate to raise any issue they had.

Staff meetings took place every few months and staff we spoke with told us they were able to raise any issues and were confident they would be listened to.

We found that effective systems were in place to monitor the quality and safety of the service and help ensure the provider had an oversight of the home.

The manager had notified the Care Quality Commission (CQC) of most events and incidents that occurred in the home in accordance with our statutory notifications.

Willow Gardens

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 took place on 27 May 2016 and was unannounced. The inspection team included an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We looked at the notifications the Care Quality Commission (CQC) had received from the service and we spoke with the commissioners of the service.

During the inspection we spoke with the registered manager, regional manager, six members of the care team, seven people living in the home, and the relatives of four people.

We looked at the care files of four people receiving support from the service, five staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living in Willow Gardens. One person told us, "I feel very safe here" and another person said, "The staff are always checking on me; I have no worries." Relatives we spoke with agreed. One relative told us, "I know [relative] is being looked after and is safe and well."

We spoke with staff about adult safeguarding, and they were knowledgeable regarding the procedures and how to raise concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and details of the local safeguarding team were available within the policy. Staff had signed to confirm when they had read the policies and procedures of the home. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock and other records for people living in the home. A medicine policy was available for staff and included guidance on areas such as actions to take in the event of a medicine error, self-administration, controlled drugs, safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. Staff had completed training in relation to safe medicine administration and this was renewed every two years. Medicines were administered by trained nurses, though training was underway to enable staff recruited to the new nursing assistant role to administer some medicines.

Medicines, including controlled medicines, were stored securely in locked clinic rooms when not in use. We did observe a trolley left unattended when the emergency buzzer went off. The staff member had locked the trolley before leaving it, but had left a sealed blister pack of medicines on top of the trolley when they went to respond to the emergency bell. This meant that vulnerable people had access to medicines that may not have been prescribed for them. The registered manager addressed this with the staff member.

The temperature of the rooms and the medicine fridges were recorded daily and were within recommended limits. We observed the MAR charts and found that there were checks in place to monitor the completion of MAR charts each day, though we did identify a small number of gaps in the recording of administration of medicines within the MAR charts. Therefore it was not documented that people had received their medicines as prescribed. This could increase the possibility of medicine errors occurring. Regular counts were also in place to check the stock balance of medicines.

Regular medicine audits were completed which looked at areas such as staff training, recording of room and fridge temperatures, use of PRN (as required) medicines and completion of MAR charts. The audit completed in May 2016 showed 100% compliance had been achieved. People we spoke with told us staff managed their medicines for them and did not raise any concerns regarding their medicines.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, choking, moving and handling

and pressure relief. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place, such as a referral to the speech and language therapist or dietician, regular weight monitoring or pressure relieving equipment.

Care plans also included personal emergency evacuation plans (PEEPs), which provided information to staff on how to support the person to safety in the event of an emergency. The PEEPs provided information to ensure people could be supported to a safe place, but did not always provide information on how to support the person to evacuate the home should that be necessary. For instance, one person's PEEP advised staff that the person would require staff to assist them into a wheelchair and wheel them to a safe place. Their bedroom was on the first floor and there was no guidance as to how the person would be supported to get down the stairs should they need to evacuate the home. We discussed this with the registered manager who advised there were evacuation sledges to support people down the stairs if needed and agreed to review all PEEP's to ensure adequate information was available to maintain people's safety in the event of an emergency.

We looked at how the home was staffed. On the day of inspection there were two nurses, seven care staff, the registered manager, administrator, chef, maintenance person, laundry assistant and three domestic staff on duty, supporting 42 people living in the home. Most people living in the home told us there was enough staff to meet their needs in a timely way. One person told us, "The staff are always about, asking if I'm ok" and relatives we spoke with did not raise any concerns regarding staffing levels within the home. Our observations showed us that there were sufficient numbers of staff on duty during the inspection. For instance, we observed two staff members sitting next to people's bed in the morning, chatting to them whilst supporting them to eat their breakfast. Staff we spoke with agreed the staffing levels were adequate and that people did not have to wait for care they needed. One staff member told us, "Staffing levels are all good because we have our rotas one month in advance. If we have a problem with a shift, staff will always try and change it between ourselves so it is regular staff."

The registered manager completed a dependency tool each month which identified the required number of staff to meet people's assessed needs. The registered manager told us they overstaffed to reduce the need of using agency staff as they felt this helped with continuity of care and the usual staffing levels during the day were two nurses and seven or eight care staff. Overnight there was usually one nurse and three or four care staff. We looked at staff rota's which reflected the staffing levels described by the registered manager.

We looked at how staff were recruited within the home. We looked at five personnel files and evidence of application forms, photographic identification, appropriate references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. The registered manager renewed staff DBS checks every three years to help ensure they remained current. We found that effective processes were in place and safe recruitment practices were followed.

We looked at procedures in place to ensure on-going monitoring of nurses' registration and found the registered manager monitored and recorded these checks regularly.

We reviewed accident and incident reporting within the home and found that accidents were recorded appropriately. Any actions required were completed, such as a referral to the falls prevention team or ordering of assistive technology equipment. An audit was completed of all accidents to look at any potential trends and enable the registered manager to take appropriate action.

Arrangements were in place for checking the environment to ensure it was safe. A maintenance person was employed and there were clear records maintained regarding checks on the environment and equipment. Internal checks were completed regularly to help ensure the environment and equipment remained safe. This included weekly testing of the fire alarm, checks on portable electrical equipment, bed rails, profile beds, nurse call bells, fire doors, wheelchairs and water temperatures.

External safety checks had been completed to help ensure the safety of the building and equipment. We saw certificates for areas such as emergency lighting and maintenance of fire fighting equipment, legionella, gas, electric, slings and hoists and the nurse call system and these were in date.

There were no concerns raised regarding the cleanliness of the home.

Good

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that two DoLS applications had been made, but no authorisations were in place at the time of the inspection. Records showed and staff we spoke with confirmed that they had completed DoLS training and a policy was in place within the home that staff had signed to confirm they had read the policy.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, we observed staff asking people if they could support them at lunch time to eat their meal, before entering a person's bedroom or providing personal care. Care records we viewed showed that people's consent was sought in areas such as information sharing and photography.

When people were unable to provide consent, mental capacity assessments were completed. We viewed a capacity assessment in one care file which recorded that the person lacked capacity. The capacity assessment tool used did not record the decision needed to be made with the assessment, however the reverse of the form included best interest decisions and this clearly recorded what decision the person lacked capacity to make. It also included decisions agreed in their best interest after consultation with relevant people. Separate assessments were used for individual decisions that needed to be made. The registered manager agreed to ensure the decision was also clearly recorded on the front of the form for clarity.

We looked at staff personnel files to establish how staff were inducted into their job role. All files we viewed included an induction which covered areas such as health and safety and policies and procedures of the service. New staff received a handbook which provided information on many areas and included equal opportunities, good conduct, whistle-blowing, equality and diversity and training and development. The registered manager told us that all new staff completed what the service considered to be mandatory training before commencing in post and then shadowed existing staff and this was evident in the records we viewed. The registered manager also told us that the care certificate training could be accessed through the eLearning system in place, though we did not see any evidence of staff having completed this training.

We looked at ongoing staff training and support. Staff told us they felt well supported and records showed that they received regular supervisions and an annual appraisal to help support them in their role. One staff member told us, "We have supervision every other month and appraisals every 12 months. These are very

helpful."

Records showed that staff had completed training in areas the service considers mandatory, such as infection control, dementia, moving and handling, use of bed rails, safeguarding, first aid, fire safety and health and safety. Staff told us they had access to regular training and could request specific training if they felt they required it. One staff member told us, "The group discussions on our study days are very good and really helpful." For trained nurses, there were clinical courses available, such as catheter care, use of feeding tubes and wound care. People living in the home told us staff were well trained. One person told us, "The staff here are brilliant; they really know what they are doing".

Staff we spoke with told us they felt well supported and were able to raise any issues with the manager or senior staff when required. One staff member told us, "We have really good management support here, it's brilliant."

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the dietician, speech and language therapist, GP, optician and chiropodist. People told us the staff supported them to access the GP and escorted them to hospital appointments when needed. One person told us, "They sort out all my doctors' appointments. I don't have to do anything."

We observed the lunch time meal in one of the dining rooms. We observed staff supporting people in a caring and attentive way. People were not rushed whilst eating. Menus were available in easy read / large print and we heard staff asking people what they wanted to eat. The registered manager told us that the menus were created in conjunction with people who lived in the home. There had been tasting sessions available to people to enable them to try meals before they were included in the menu. Records show that the last tasting session was held in April 2016. Staff told us people were asked for their feedback regularly regarding meals and records we viewed showed meals were discussed at resident meetings.

Themed food nights were held and people's family members were encouraged to attend. In the week prior to the inspection a Chinese food evening was held. Small kitchen areas were available for people who were able to make their own drinks during the day and staff regularly asked people whether they wanted a drink.

We asked people about their view regarding the food available and feedback was positive. One person told us, "The food is great; my favourite is the fish and chips with mushy peas" and another person said, "The food is lovely, we also have a choice."

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring and treated them with respect. One person told us, "Staff are very good", another person said, "I feel the staff really care for me" and another person told us, "The staff are very caring." Two relatives told us how staff not only supported them, but also their family members. Relatives we spoke with all agreed that the staff were caring. One relative told us, "People need the care and the staff make sure they get it" and another relative said, "The care here is really good. I couldn't say a bad word about the place."

We observed people being treated kindly by staff, using tactile gestures as a way of reassuring people. Interactions between staff and people living in the home were warm and genuine. We heard staff chatting to people and they were laughing and smiling.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection, such as staff knocking on people's door before entering their rooms and referring to people by their preferred name. Personal care activities were carried out in private and people did not have to wait long if they needed support. People were given plenty of time to eat their meals; they were not rushed in any way and support was provided in a relaxed and timely manner.

People we spoke with told us that staff treated them with respect and maintained their dignity. There was an allocated dignity champion and a copy of the dignity charter was on display for people to read. Bedroom doors had signs on that could be turned to show that personal care was being provided in the room. This would help maintain people's privacy and dignity.

Care files were stored securely in order to maintain people's confidentiality.

People we spoke with told us they had been involved in care planning, though records we looked at did not all reflect this involvement. Relatives told us they had been involved in creating personal profiles for their family members.

The registered manager told us and records showed, that people had been involved in decisions affecting them within the home. For instance, one document recorded the involvement a person had in redecorating their room; there was evidence of a consultation regarding the menu and results of taster sessions. People had also been involved in deciding upon holidays for the coming year and had developed a list of 11 questions that they would like to ask potential staff at interview. The register manager told us these questions would be utilised when interviewing future staff.

People were encouraged to maintain their independence by staff. For instance, we observed a staff member gently encouraging and supporting a person to use their cutlery during lunch. Records showed that referrals were made for support from a physiotherapist or falls team when people's mobility needs changed.

We found on discussion, that staff knew the people they were caring for well, including their needs and

preferences. People and their relatives all agreed that staff knew people well.

We observed relatives visiting throughout the inspection. The registered manager told us there were no restrictions in visiting, encouraging relationships to be maintained. The registered manager asked relatives not to visit at meal times unless they were joining their family member for a meal to help ensure people were not rushed or disturbed when eating. Relatives we spoke with told us they were always made welcome and we observed people's relatives being offered refreshments during their visit.

For people who had no family or friends to represent them, contact details for a local advocacy service were available and were on display within the home for people to access. One person was being supported by an advocate and the registered manager told us they would assist people to make a referral if required.

Good

Is the service responsive?

Our findings

We looked at how people were involved in their care planning. All people we spoke with told us they had been involved in the creation of their care plans. Most care files we viewed reflected people's involvement through the completion of consent forms and all were reviewed regularly. Reviews were detailed and related to each area of support provided to individuals.

Care plans we viewed had been updated when people's needs changed. For instance, one file we viewed reflected that the person had lost weight recently; this was recorded within the care plan as well as confirmation that a referral had been made to the dietician for specialist nutritional advice.

We viewed a number of care files that contained a pre admission assessment; this ensured the service was aware of people's needs and that they could be met effectively from admission.

We observed care plans in areas such as personal care, mobility, nutrition, communication, mental health, continence and skin integrity. Care plans were detailed and informative and focused on the needs and preferences of the individual. Care plans provided staff with specific information to enable them to support people safely. For instance, one person's care plan advised the person was at risk of choking and guided staff on how to support the person and reduce the risks regarding this, such as sitting up for half an hour after meals, ensuring fluids provided were of the correct consistency and to support the person to eat meals slowly.

People's preferences were recorded in areas such as food and drinks, activities and daily routines. One person told us, "I can do whatever I want, I just let the staff know and they will do anything to help me." People told us they had a choice regarding the gender of carer who supported them with their personal care needs, though none of the people we spoke with had a preference.

Care files contained life histories for people which enabled staff to get to know people, understand their experiences and backgrounds and provide support based on their preferences. Relatives we spoke with confirmed they had been involved in the creation of these life histories.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files. Relatives we spoke with told us they were kept informed of any changes to their loved one's health and wellbeing. One relative told us, "All the staff are really lovely; they greet you when you come in and tell you what's been happening."

People had access to call bells in their rooms to enable them to call for staff support when required. People told us that staff responded to their call bells in a timely way.

We looked at the social aspects of the home. An activities coordinator was employed four days per week and schedule of activities was planned and advertised so people could see what was on. Activities included

swimming, bingo, films, chair exercises, bowls, meals out, shopping and coffee mornings. A coffee morning took place during the inspection and we observed the activity coordinator interacting with people, discussing relevant topics and encouraging people to participate, paying particular attention to people who appeared quiet or shy. People were laughing and there was a relaxed atmosphere during the coffee morning.

The registered manager told us a few people went on holiday to Blackpool last year and a holiday was planned to Llandudno later this year. Photographs from previous holidays and activities were displayed around the home. The registered manager also told us staff regularly supported people to go out for the day, such as to Southport. One relative told us, "[Staff] keep people entertained."

We looked at processes in place to gather feedback from people and listen to their views. Records we viewed showed that quality assurance surveys had been completed by people living in the home and relatives in April 2016. The registered manager had not collated the results at the time of the inspection, however comments gathered from people during meetings were displayed on a board reading "You said, we did." This included suggestion of a barge holiday which had been booked, more roast dinners on the menu (which had been added) and greater choice of films. The registered manager had purchased a number of box sets for people to watch.

People's views were also gathered through regular meetings. The registered manager told us they held cheese and wine evenings as well as resident meetings to encourage people to attend and share their opinions of the service. Records we viewed showed that people discussed meals, activities and the general running of the home during these meetings. The minutes from these meetings reflected that people had requested support to go to the cinema which the registered manager told us had happened and a games console had also been purchased at the request of people living in the home. There was also a suggestion box available in the foyer to enable people to provide comments anonymously should they choose to.

People had access to a complaints procedure and this was displayed within the home. We viewed the complaints records which showed that complaints received had been investigated in line with the complaints procedure. People we spoke with were aware of how to raise any concerns they may have and felt they would be listened to and relatives agreed. The registered manager told us they had an open door policy and all people we spoke with agreed. One staff member told us, "[Manager] has an open door policy for everybody, residents, family and staff."

Good

Is the service well-led?

Our findings

The home had a registered manager in post. We asked people their views of how the home was managed and feedback was positive. One person told us, "My family are happy I'm here because it's so well managed." A staff member told us, "Everybody here works together. It's a nice place to work" and another staff member said, "We have really good management support here, its brilliant."

Feedback regarding the registered manager was also positive. A person living in the home told us, "[Manager] is pretty good she sorts lots of things out for us" and another person said, "[Manager] is just great; she never lets us want for anything." Comments from relatives included, "They just sort everything for you", "We can approach [registered manager] about anything and she gets it sorted" and "[registered manager] listens to you if you've got problems."

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff told us they were encouraged to share their views regarding the service.

We looked at processes in place to gather feedback from people and listen to their views. As well as resident meetings and quality assurance surveys, there were also regular staff meetings held to ensure views were gathered from staff. Records we viewed showed that staff meetings took place every few months and covered areas such as ways of working, infection control, mental capacity, DoLS, care planning and medicines management. Staff we spoke with told us they were able to raise any issues and were confident they would be listened to. One staff member told us, "We have regular staff meetings and [registered manager] genuinely listens to our suggestions if things need to change."

During the visit we looked at how the registered manager and provider ensured the quality and safety of the service provided. The provider employed a number of people to complete audits at Willow Gardens to help ensure the quality and safety of the service. The area manager was at the home during the inspection and told us they visited at least once per month to complete an audit and support the registered manager and staff team. Records showed that the monthly audits included areas such as updating any outstanding action plans, monitoring complaints, ensuring staff supervision and training had been completed, care file audits and reviewing any accident reports. The area manager also reported on comments received from staff and people living in the home.

A quality team were also in post and audits were completed in areas such as involvement and inclusion and health and safety as well as general quality assurance audits. The registered manager completed audits in areas such as care planning, medicines, infection control, wheelchairs, mattress integrity, meal time experience, laundry, kitchen and staff files. Audits we viewed recorded actions where necessary and most of these were signed and dated when completed. For instance, a health and safety audit identified that a risk assessment was required for staff members during pregnancy and we viewed the completed risk assessment.

The area manager told us a conference call was held every two weeks which included senior staff such the area manager, chief executive, the head of quality and the head of health and safety. Outcomes from audits and updates on outstanding action plans were discussed during these meetings. This meant that systems were in place to monitor the quality and safety of the service.

The manager had notified the Care Quality Commission (CQC) of most events and incidents that occurred in the home in accordance with our statutory notifications. Records showed that there were two incidents that the service had referred to the local safeguarding team, but had not notified CQC of. The registered manager told us this was because they had not been progressed to safeguarding investigations as they did not meet the threshold. The registered manager had notified us of all other incidents that had occurred within the home. We advised the registered manager that CQC should be notified of all allegations of abuse and the registered manager agreed to ensure this happened. This meant that CQC would be able to fully monitor information and risks regarding Willow Gardens.