Stephen Geach

Willow Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 April 2016 and was an unannounced inspection.

Willow Lodge Care Home provides accommodation and care for up to 32 older people, most of whom have a diagnosis of dementia. The home is purpose built over three floors. At the time of our visit there were 29 people living at the home.

The service has a registered manager. 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 spoke positively about the care they received. They told us that staff were kind and friendly and that they were able to participate in a wide range of activities and outings. During our visit we heard lots of laughter and observed that people and staff enjoyed good relationships.

People felt safe at the home. Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely. The home was clean and there were systems in place to protect people from the risk and spread of infection.

There were enough staff to meet people's needs. Staff had received training and were supported by the management through regular supervision and appraisal. Staff were able to pursue additional training, such as in supporting people living with dementia which helped them to improve the care they provided to people. The provider was making improvements to the environment to make it more dementia friendly, such as by improving lighting.

People told us that staff treated them with respect. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We have made a recommendation about reviewing the use of locks on bedroom doors to ensure that people's freedom of movement is not unnecessarily restricted.

People enjoyed the food and were offered a choice of meals. Staff were attentive to people's needs and supported those who required assistance to eat or drink. People's weight was monitored and prompt action taken if any concerns were identified.

People were involved in planning their care and were supported to be as independent as they were able. Where there were changes in people's needs, prompt action was taken to ensure that they received

appropriate support. This often included the involvement of healthcare professionals, such as the GP, district nurses or optician.

The registered manager had a system to monitor and review the quality of care delivered and was supported by the provider. People, their relatives and staff felt confident to raise issues or concerns with the registered manager. Where improvements had been identified prompt action had been taken.

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 said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and reviewed to help protect people from harm.

There were enough staff to meet people's needs and keep them safe.

People received their medicines safely.

The home was clean and there were clear systems in place to minimise the risk and spread of infection.

Is the service effective?

Requires Improvement

One aspect of the service was not effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act. We found, however, that keypads on bedroom doors restricted some people's freedom of movement.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

The provider was making further improvements to the premises and looking at ways to make it more dementia friendly.

Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans provided comprehensive, detailed information about people and guidance to staff.

An interesting and varied programme of activities and outings was available. People who spent time in their rooms received one to one time from activities staff.

People were able to share their experiences and were assured of a swift response to any concerns.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager and leadership team. Staff were clear on their responsibilities and told us they were listened to and valued.

The registered manager used a series of audits to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

Willow Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 April 2016 and was unannounced.

Two inspectors undertook this inspection.

Before the inspection, we reviewed three previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at care records for eight people, medication administration records (MAR), monitoring records for food and fluid, accident and activity records. We also looked at three staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 11 people using the service, one relative, the registered manager, the head of care, the assistant head of care, three care staff, two housekeeping staff, the chef, the activity coordinator, the administrator and two agency care staff. We also met with three district nurses and a GP who were visiting the service and asked them for their views. Following the inspection, we contacted one relative, the home's training provider and a district nurse to ask for their views and experiences. They consented to their views being shared in this report.

Willow Lodge Care Home was last inspected in July 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe and that they had confidence in the staff who supported them. One relative told us, "Knowing Mum is safe and happy is a huge bonus to us as a family". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One staff member said, "If I thought there was any abuse at all happening I wouldn't hesitate and would report it straight away".

The registered manager had made safeguarding referrals to the local authority in response to any concerns and demonstrated a clear understanding of her responsibilities. Staff told us that they felt able to approach the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team. One said, "If you don't think they have done anything about it, there are also numbers on the notice board that you can call or you can send anonymous emails".

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, pressure areas or in relation to being socially isolated, they had been assessed. For each risk identified, guidelines were in place to describe how to minimise the risk and the support that people required from staff. For example, moving and handling assessments detailed the number of staff needed to support the person, any additional considerations, such as one sided weakness following a stroke, and the equipment to use. The assessment considered variation in people's abilities, for example if a person was unable to weight bear on a particular day staff were guided to use a fully body hoist and sling. As people's abilities changed, their support was reviewed.

Following incidents people's support had been reviewed and updated in order to minimise the risk of a repeat event. We read that some people used non-slip socks at night to reduce their risk of falling if getting up to use the commode. A walking stick holder had been purchased whereby the person could clip the stick to the chair where they were sitting. This helped to minimise the risk of trips and falls. The district nurses that we spoke with told us that the provider was quick to respond to their suggestions for equipment to support people's care. They told us that a pressure relieving cushion had been purchased for one person who was at risk of skin breakdown. This meant that the person was able to enjoy time in the communal areas and that their risk of developing pressure areas was reduced.

Each person had a personal evacuation plan in place which described the support they would require from staff in an emergency to leave the premises. Evacuation equipment was available to safely evacuate people from the first and second floor. The provider had an agreement with a nearby service to share facilities in the case of emergency.

People told us that staff responded quickly if they asked for assistance. Most people felt that there were enough staff on duty. Two people felt that there were fewer staff at the weekend. We looked at the rotas and discussed this with the registered manager. We found that there were the same number of care staff but

fewer ancillary staff working on weekend shifts. In response to the provider's survey, one relative had written, 'Always seem to have plenty of staff'.

The registered manager completed a monthly dependency assessment for each person which was used to determine the number of staff required. This assessment considered the support that people required with mobility, continence, eating, personal care, communication and orientation. Each area of need received a score and these were added together to give a dependency level, ranging from low to very high. The registered manager considered the overall dependency level of people using the service and the layout of the building to determine safe staffing levels for the morning, afternoon, evening and night shifts. Staffing rotas confirmed that the staffing level had been maintained in accordance with the planned staffing numbers. In addition to the care staff, the provider employed housekeeping, kitchen, administration and maintenance staff. This meant that care staff were able to focus on providing support to people. Staff told us that they were able to meet people's needs and that they had time to spend with them.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. For staff coming from outside Europe their eligibility to work in the UK was checked. These measures helped to ensure that new staff were safe to work with adults at risk.

People received their medicines safely. Staff who administered medicines had received training and their competency had been assessed before working independently. There were recorded details of how each person liked to receive their medicines. Medication Administration Records (MAR) demonstrated that people had received their medicines as prescribed. Where medicines were prescribed on an 'as needed' basis (PRN), there was clear guidance to describe the dose and the expected effect. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. Topical creams were administered consistently though we found a few examples of creams that had not been dated on opening. The head of care quickly removed these products and replaced them with new. The date of opening is important as a medicine can lose its effectiveness if stored for longer than recommended by the manufacturer.

Medication was stored in locked cabinets that were clean and well organised. The cabinet was attached to the wall by a chain or stored in a locked room. We identified that some people had bleach-based denture cleaning tablets stored in their rooms. We discussed this with the registered manager and head of care since this would present a risk to people if ingested. Before we left the service, the head of care had removed these tablets from people's bedrooms and stored them securely in the medicines trolley. Following our inspection, the registered manager sent us a copy of a new staff policy regarding denture cleaning products which had been shared with staff to raise awareness of the risks and to guide them in the safe storage and use of these products.

The home was clean and fresh throughout. One relative told us, "It's the only place I found that didn't have a smell". Staff had been trained in infection prevention and control and there were systems in place to minimise the risk of infection. These included regular cleaning schedules and checks which covered areas of the home as well as equipment including shower heads, handrails, wheelchairs and walking frames. When a room or piece of equipment had been cleaned staff placed a green sticker with the time and date on it. The registered manager told us that this was a useful visual reminder. Staff used personal protective equipment such as gloves and aprons to protect people and minimise the risk and spread of infection.

Requires Improvement

Is the service effective?

Our findings

People told us that staff were skilled in their work and understood how they liked to be supported. Relatives were equally positive. One wrote to us, 'Mum is well looked after. I have absolutely no concerns about how she is cared for'. Staff felt confident and told us that they received appropriate training. One staff member said, "The training is good, it's all covered". The provider used an external training company to deliver the majority of staff training. Courses included, safeguarding, fire, dignity and respect, nutrition and hydration, moving and handling, dementia awareness, infection control, first aid, the Mental Capacity Act 2005 and personal care. Most courses were offered twice each year and the administrator maintained a record of staff attendance. Training for the majority of staff was up to date. We noted that one member of night staff had yet to complete some courses including dementia awareness, food hygiene and fire. The registered manager explained that they were looking at online alternatives for some courses which could be used by night staff who did not always find it easy to attend training. A new online records system was also being introduced. This would help to keep track of training as it would automatically flag when a course was due for renewal.

Staff attended regular supervision meetings and an annual appraisal with their line managers. These meetings provided an opportunity to discuss their roles, professional development and any concerns or ideas. There were also regular observations of staff practice which formed part of their ongoing supervision. One staff member said, "If I do anything that isn't up to standard, I'd rather know". Staff told us that they were able to pursue further training such as diplomas in health and social care. Two staff had been trained as infection control champions and others were booked to attend specialist training in dementia care, such as communication in dementia or nutrition in dementia. The district nurses told us that the registered manager was receptive to suggestions about additional training which may improve the support that people received. We saw that staff had been asked to complete a learning and development plan setting out their goals and future training wishes.

New staff completed a period of induction, which included shadowing of experienced staff. During this period, a checklist was used to ensure that key areas were discussed and explained. For example tasks to be demonstrated and understood included, infection control, good laundry practices, use of pressure relieving equipment and how to check and record water temperature. During the first two weeks, a daily supervision record was completed by the new staff member and their mentor. This highlighted areas of good practice and suggestions for additional training. New staff told us that they felt supported throughout their induction and felt that it had equipped them with the necessary knowledge and skills to care for people. New staff were able to work towards the Care Certificate which is a nationally recognised qualification. We saw that one staff member had completed this qualification in November 2015.

People told us they were able to choose how they spent their time. During our visit we observed that staff involved people in decisions and respected their choices. In people's care plans we read, '(Name of person) can verbally communicate her wishes, choices and preferences daily' and, 'I can communicate verbally when I would like to retire to bed'. In the daily records we noted examples of people who had refused support, such as a bath or shower in the morning. Staff had respected people's decisions and had passed

this information on to their colleagues at handover so that the person could be offered again at another time of day. One staff member said, "We need to get consent before doing things for them. One resident understands but cannot speak. You have to allow time to let her answer".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the 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. At the time of our inspection, the registered manager had assessed that 20 people lacked capacity to consent to their care, treatment and accommodation at the service. Applications to deprive people of their liberty had been made to the 'Supervisory Body' for authority to do so, of which five had been granted.

Staff understood the requirements of the Mental Capacity Act (2005) and put this into practice. One staff member said, "It is about making sure that people have choice and freedom and not restricting this. It also means that you have to be aware of when sometimes people might have areas where they can't make decisions for themselves and meetings have to be held with people involved with them to ensure that they are kept safe". Another told us, "Sometimes MCA and DoLS would have to be put in place if people could not make decisions for themselves but this would all have to be verified to ensure it was in their best interests and we were not stopping their liberty". We noted that staff took steps to promote people's independence. One person had wanted to visit a local town independently. Staff had initially travelled with them by car and then by bus. They had arranged a mobile phone for the person and met them from the bus on arrival. Unfortunately the person became very confused and was not able to travel alone but staff had worked hard to assess if this was something the person was safe and confident to do. Another person had an advocate who worked with them on financial decisions.

The home had CCTV in the communal areas. Information provided to people stated, 'CCTV installation is to enhance security and service user safeguarding issues. Images are not viewed unless a requirement to investigate an incident of safety or security'. The use of CCTV was discussed with people on admission and their consent to its use was recorded. Similarly where people used equipment such as sensor mats to alert staff when they moved, consent had been obtained. Where people were unable to understand and make a decision for themselves, staff had involved representatives and healthcare professionals in making a best interest decision.

We observed that the internal doors, including people's bedrooms, had been fitted with keypads. The registered manager explained that some people had been distressed by others entering their personal space and that the locks offered security for people's belongings. One person was very happy with the new lock and was able to operate it independently. They told us, "I can use the keypad and it doesn't worry me at all". Another person had requested that the lock on their bedroom be deactivated and this was arranged. We found, however, that some people were unable to use the locks and as a result required staff assistance to enter their bedrooms. We discussed this with the registered manager as the installation of locks on every bedroom door did not appear to be in the best interest of some people. The registered manager had not

considered the locks in terms of a restriction on people's free movement. She told us that she would review the DoLS applications submitted and update them where necessary to include the use of locks on internal doors. We recommend that the registered manager considers a more person-centred approach to keeping people's belongings safe to ensure that people's freedom of movement is not unnecessarily restricted.

People told us that they enjoyed the food. One person said, "I'm happy with the food, there are usually two meals to choose from". During lunch one person said to their neighbour, "This is lovely, the meat just melts in your mouth". The provider purchased frozen meals from an external company and a choice of dish was offered each day. The meals looked appetising and were nicely presented. People were offered condiments and extra gravy, along with second helpings if they wished. People who required assistance to eat were supported by staff in an unhurried manner. For one person with some sight difficulties, staff asked them if they would like their meal cut up and signposted them as to where everything was positioned on the plate. Staff maintained records of how much each person had eaten at each mealtime and a record of people's weight was kept on a monthly basis. When there were concerns we saw that food and fluid charts were used effectively and that the GP and district nurses were informed. One person who had been noted as losing weight on admission had shown a steady increase in weight two months after admission.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. Professionals told us that staff contacted them promptly if they had concerns and that staff followed their advice. One district nurse said, "The things we have put in place, she's (the head of care) acted on". We saw that the GP had been contacted for one person who appeared 'chesty' and that another person had been to see the optician as staff were concerned their eyesight was deteriorating. The GP carried out a medication review for each person annually.

The provider was making further improvements to the premises. Healthcare professionals who had visited the service over a number of years told us of the significant improvements that had taken place. The communal areas had been divided to offer people quiet spaces to sit if they preferred. A new vintage tea room was due to open in the garden before the summer. The dining room was separated from the lounge by a large fish tank which provided an interesting feature wall. Double bedrooms were being split into single rooms and a second communal downstairs toilet was due to be added. In the downstairs bathroom, a tracking hoist had been fitted which saved space and made it easier for staff to manoeuvre when assisting people to and from the bath. The registered manager told us that lighting had been improved and that they were working with the provider to make further improvements to the environment and to make it more dementia friendly.

Good

Is the service caring?

Our findings

People spoke highly of the staff. One said, "It's delightful here in many ways. Everybody tries to be very kind to you and they have a very endearing attitude among them". Another told us, "The staff here are very kind people and they make sure that I have nice things, it is a nice place. I don't like to join in with too many activities and they come and sit beside me and talk". Relatives also spoke of staff kindness. One wrote to us, 'The staff are amazing, all of them. I have watched staff interacting with the residents when they think I'm not watching and I have seen nothing but kindness from the staff'. Another said, "She's really happy, they're super. She's got people who will give her a hug or have a natter". A third had written to the provider saying, 'You are all wonderful people. I can sleep at night knowing my Mum has such great care, friendship and love given to her day by day'.

We observed that people and staff enjoyed relaxed and positive relationships. There was lots of laughter and chat in communal areas. One person told us, "That's what we're here for, to have a laugh!" Another person told us how they had spoken with a staff member the previous week as they were feeling a bit down. They said the staff member had really helped to cheer them up. In a recent relatives' survey sent by the provider, one relative had written, 'I'm very pleased with the care. I feel most of the staff genuinely care about my mother's health, welfare and well-being. You seem to treat each resident as a valued individual'. In a card of thanks, another relative wrote of the dedication, warmth and love given by staff.

The registered manager had introduced Recognition of Care and Kindness (ROCK) awards whereby people, relatives, health professionals or external visitors could nominate staff members to reward recognition of care and kindness. Staff presented with the award were given a badge of recognition. Staff spoke positively about the awards and the registered manager told us that it had lifted morale.

Most people could not remember being involved in drawing up their care plans but they all told us that staff knew them well and remembered their day to day preferences. We heard staff asking people if they wished to participate in activities, which channel they wanted to watch on the television and if they wished to return to their bedrooms. Staff told us that they discussed the care plans with those people who were able. One said, "It's nice to have a sit with them to discuss it and have a cup of tea". People had also been involved in deciding on the décor of the home. The registered manager told us people had given a veto to one wallpaper suggestion and that an alternative had been agreed.

People told us that they felt respected and that staff were mindful of their privacy. One person said, "Staff are very kind and nothing is too much trouble at all. They are always respectful and ask me what I want". We observed that staff always knocked on people's doors and waited for a response before entering. When they used walkie talkies to communicate with one another, they used room numbers rather than names to maintain people's privacy.

The registered manager had carried out a survey entitled 'Measuring dignity' in October 2015. The survey included questions such as, 'How well do you feel staff get to know people using the service as a person' and, 'How well do the staff team manage to stay patient, polite and courteous'. The survey had been open

to visitors but the responses were from staff. The registered manager had collated the information to help identify any areas for improvement. The feedback was positive, with some areas for improvement such as maintaining privacy in shared rooms being addressed by the move to make all of the bedrooms single occupancy. One staff member told us, "We work as a team here to support people and there are daily observations by the manager to ensure that residents are being treated with respect and dignity".

Good

Is the service responsive?

Our findings

Staff knew people well and understood how they liked to be supported. When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. One relative commented in the provider's survey, 'Mother's admission was dealt with superbly by senior staff'. We noted examples of individual preferences, such as to have the bathroom light left on at night, to drink tea from a cup and saucer or the person's favourite TV programmes. One relative told us, "The people they are looking after are number one. She's really well taken care of". The relative added, "They keep me well informed. Everything is about Mum's wellbeing".

Each person had a care plan which detailed the daily tasks they were able to manage independently and those where they required support from staff. For example we read, 'I can take myself to the toilet' and, 'I have top dentures at the moment and can take them out and put them in myself'. Information was arranged into sections such as mobility, washing and bathing, continence, oral care, communication and hobbies. People were encouraged to do as much as possible for themselves. In one care plan we read, 'Do not take over task – maintain skills'. The head of care told us that they felt very proud of how they worked with people little by little to build up their skills, such as by building confidence and strength in walking after a stay in hospital.

Staff maintained records of the support that people received each day. Any changes or updates were shared at shift handover and staff were required to sign in order to demonstrate they had understood the information. Each person's care plan was reviewed a minimum of once per month and any changes were clearly documented. The registered manager explained that they were moving to an electronic records system whereby staff would record daily notes directly onto a handheld device. The registered manager hoped that this would further improve the accuracy of records.

Staff were quick to respond to people's physical and emotional needs. Where people were unable to use a call bell to request assistance, staff carried our regular checks to ensure their wellbeing. If a person was unwell the frequency of the checks were increased. We observed as a staff member quickly moved to reassure one person who was becoming distressed. The staff member spent a significant amount of time with the person talking over their worries and offering reassurance. After a long conversation, the person started to cheer up.

There was a varied and interesting activity programme available for people six days per week. The activity coordinator told us that this would shortly be increasing to seven days. People were able to contribute ideas and suggestions to the programme during residents' meetings or directly with the activity coordinator. On the day of our visit there was a craft activity during the morning and a sing-along in the afternoon. One person joked, "We'll make a row, I don't know about a singsong!" At lunchtime ten people went out to a local pub for lunch. One person told us, "Yesterday I went to singing for fun, we went as a group". Another said, "I've got puzzles and I read. We're going out today. They have a minibus".

People and relatives spoke highly of the programme on offer and of the activities coordinator who was

described by one relative as having an 'infectious personality'. The week's programme, along with forthcoming special events was displayed in the home. The in-house programme included reminiscence sessions, reading newspapers with staff, an in-house sweet shop and poetry readings. There were also outside entertainers and people had monthly bus trips to local pubs and places of interest. Relatives were invited to join in with trips out or to attend special events such as an owl display that was planned. A relative said, "They do a lot of activities, there is a lot of kindness. Having the activity staff is really good, it allows time on an emotional and creative level".

We asked how people were protected from the risk of social isolation if they did not wish to join in the activities of offer. The activities coordinator showed us that people were risk assessed and one to one sessions were offered in their rooms. These could include hand care and nail painting, reading newspapers or just spending time with people. During the morning one person was supported by staff to do some dusting which they appeared to really enjoy, another was discussing the news with a staff member as they read the paper. We were told that many of the female residents in the home liked to have their makeup and jewellery on each day. The part time activities assistant had qualifications in theatrical make up and people enjoyed being supported by her. All attendance at activities or refusals to join in were recorded on the new electronic records system. This allowed the co-ordinator to assess if someone was becoming isolated or to identify what groups and activities people liked to join with. Information about each person was recorded on the system every day.

The activities co-ordinator had trained as a 'Dementia Champion' for the Alzheimer's Society and had delivered dementia awareness sessions for people, staff and families. Through these sessions staff and relatives had become 'Dementia Friends'. We observed that some adaptations had been made to make the environment more dementia friendly, for example by improving lighting and having a coloured toilet seat and crockery to aid people who struggled with visual perception. We discussed with the registered manager how pictorial menus or sample plates might also be useful if promoting choice at mealtimes. One great success was 'twiddle mitts' which were like an arm warmer covered in sensory materials and bells. The registered manager told us they had kept people very busy and provided a source of reassurance to some.

People felt able to voice any concerns and felt confident that they would be listened to. One person said, "If I am unhappy about anything I just tell them and they do something about it". Another told us, "They do listen if you have a worry and they also do something about it for you".
There were regular residents' meetings and a suggestions box was also available. The registered manager had taken prompt action in response to points that people raised. For example, an extractor fan had been fitted in the downstairs bathroom and a hairdressing chair and sink had been purchased. One district nurse who had raised a concern about the service told us, 'I am happy that the senior team responded quickly and effectively to our concerns raised previously'. Another healthcare professional had written in a survey response, 'Any concerns reported were actioned immediately'. People, their relatives and health care professionals had been asked for their views on the service in a survey from the provider. At the time of our visit, the responses were being returned and had not yet been collated.

The provider had a complaints policy and the complaints procedure was displayed within the home. In response to complaints the provider was extending the laundry facilities and purchasing new equipment. One relative had written in a survey response, 'Complaints are dealt with quickly and in depth and improvements usually made where needed'.

Good

Is the service well-led?

Our findings

There was a very friendly and welcoming atmosphere at the home. People were relaxed and engaged. Some people were busy in their rooms while others were involved in organised activities or were enjoying a chat with others in the lounge. One person told us, "Staff are really pretty good here and they are always smiley. It looks as if they are enjoying their job". In a response to the provider's survey one person had written, 'All very good. Gold stars. I have lived here a long time and I love it'.

Staff told us that they worked as a team and that they were able to raise any concerns with the registered manager or head of care. The registered manager promoted open and transparent practice. Incidents were clearly recorded and there was a duty of candour policy in place. Under duty of candour, the regulations state that providers must act in an open and transparent way and must notify relevant people about any incident which must be looked into, investigated and responded to with an apology if applicable.

The registered manager worked closely with the head of care and deputy head of care. She explained that when she was not available the head of care would be on shift and vice versa. This provided continuity in leadership of the service. People and staff spoke highly of the registered manager. One staff member said, "The manager is great, you can go to her with anything and she will give you time". Another told us, "You can go to (the registered manager) at any time; she just wants the best for residents and staff". Healthcare professionals also expressed confidence in the leadership of the service. The GP told us the registered manager was, "Appropriate and proportionate in her responses to contacting the surgery". A district nurse said, "At the moment I feel very confident in the home and the manager and deputy manager are very good".

The registered manager used a series of daily checks to monitor the quality and consistency of the service. Each day the senior on duty would complete a checklist of tasks including staff handover, room checks and health and safety checks in communal areas. The registered manager would then check that any actions noted in the handover report had been completed and carry out spot checks on bedrooms, equipment, staff uniform and presentation. In addition at least one staff member's practice was observed each day. This check included how they approached the person, their manner and how well they listened to the person's wishes. These checks helped the registered manager to monitor the quality of care that people were receiving and to take prompt action if any areas for improvement were identified.

The head of care carried out monthly audits on care plans and medicines. The majority of care plans had been audited in February and March 2016. To monitor other areas of the service, the registered manager had a schedule which reflected the domains of safe, effective, caring, responsive and well-led. The plan showed that over the course of the year each of the areas would be checked. In addition to internal audits, the provider commissioned a six monthly external audit of the service. The most recent visit had been in February 2016. The service had also been visited by the West Sussex Fire and Rescue Service, the pharmacy and the Food Standards Agency. No significant concerns had been identified during these audits.

The registered manager used the findings of audits to improve the quality and safety of the service. For each

audit, an action plan had been drawn up and these were shared with the provider. We noted that many of the actions had been completed promptly. Quality monitoring information, such as on falls, complaints and feedback surveys was displayed in the home for people and relatives to see and ask any questions. We found that there was an effective system in place to monitor and improve the quality of the service. A GP told us, "They have transformed the place. It has changed remarkably over the last two to three years".