Premier Nursing Homes Limited

Willowdene Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 11 July 2017.

We last inspected Willowdene Care Home in April 2016. At that inspection we found the home was meeting all its legal requirements. However, we considered some improvements were required. At this inspection we found those improvements had been made.

Willowdene Care Home is registered to provide accommodation for personal and nursing care to a maximum of 52 older people, including people who live with dementia or a dementia related condition. There were 33 people who were using the service at the time of our inspecion.

A manager was in place who was in the process of applying to become 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.

Due to their health conditions and complex needs not all people were able to share their views about the service they received. Those that could speak with us told us that care was provided with kindness and we observed that people's privacy and dignity were respected. Staff knew the people they were supporting well.

People's preferences in relation to their end of life care had been discussed and the service aimed to provide people with a home for the rest of their lives.

Some people told us they felt safe. However, staffing levels were not sufficient to ensure people's needs were managed safely. Staffing levels were increased immediately during the inspection. Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff received opportunities for training to meet peoples' care needs and in a safe way. A system was in place for staff to receive supervision and appraisal and there were robust recruitment processes being used when staff were employed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible, the policies and systems in the service support this practice. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. People received their medicines in a safe way.

The home was well-maintained and the environment encouraged the independence and orientation of

people who lived with dementia. Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for.

A complaints procedure was available. Relatives and people told us they would feel confident to speak to staff about any concerns if they needed to. The provider undertook a range of audits to check on the quality of care provided. People had the opportunity to give their views about the service. There was regular consultation with people and/ or family members and their views were used to improve the service. People had access to an advocate if required.

Staff and relatives said the new manager and the management team were approachable. Communication was effective to ensure staff and relatives were kept up to date about any changes in people's care and support needs and the running of the service.

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 were kept safe as systems were in place to ensure their safety and well-being. Staffing levels had been increased and they were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals. Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs. The environment was well-maintained and was designed for the orientation of people who lived with dementia.

Is the service caring?

Good

The service was caring.

People received individual care and staff were thoughtful about their needs to ensure people received care in the way they wanted if they did not communicate verbally.

People were encouraged and supported to be involved in daily decision making. Staff were caring and respectful. People and their relatives said the staff team were kind and patient.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

There was a good standard of record keeping to help ensure people's needs were met.

People were provided with some activities and the programme was being expanded and developed to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-managed.

A manager was in place who was in the process of becoming registered with CQC. Staff and relatives told us the manager was readily available to give advice and support. They were very complimentary about the changes that had been made in the home.

Improvements had been made by the manager and provider and were being maintained by the manager and management team to promote the delivery of more person centred care for people.

The home had a robust quality assurance programme to check on the quality of care provided.

Willowdene 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 checked 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 comprehensive inspection took place on 11 July 2017 and was unannounced.

It was carried out by an 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 a service for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We also contacted the local safeguarding teams.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

During the inspection we spoke with five people who lived at Willowdene Care Home, seven relatives, the manager, the regional manager and the compliance lead for the home, six support workers, one registered nurse, one maintenance person and two members of catering staff. The provider dialled in to listen to the feedback at the end of inspection. We looked around the kitchen. We reviewed a range of records about people's care and how the home was managed. We looked at care records for five people, recruitment, training and induction records for five staff, four people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

Relatives we spoke with told us their family members were safe at Willowdene. One relative commented, "I'm happy [Name] is here, they're getting looked after." The manager and director of operations told us staffing levels were determined by the number of people using the service and their needs. However, our observations during the inspection showed there were insufficient numbers of staff available to keep people safe. This was addressed immediately during the inspection and an additional support worker was brought on duty to assist people on the top floor. After the inspection we were told of other action that had been taken to ensure staffing levels were sufficient.

At this inspection there were 33 people who were living at the home. Staffing rosters and observations showed on the top floor 15 people, some who lived with severe dementia and displayed distressed behaviour, were at risk of falls and most of whom required two staff members to assist them because of their physical dependency, were supported by three support workers and a registered nurse. On the ground floor 18 people, some who lived with severe dementia and many who needed full staff support for all their needs were supported by four support workers and a registered nurse. One of these staff members was allocated to provide one to one support to a person at all times. We observed later in the day, after tea, the one to one staff support was not available for the person but the staff member was responsible for all the people sitting in the lounge. Overnight staffing levels included two registered nurses and four support workers.

We observed the lunchtime meal on both floors of the home. On the top floor two dining rooms were used. In one dining room one member of staff supported seven people who required less assistance and in the second dining room meals were served to eight people who were more dependent. We observed some people left the table before they had finished their food and as staff were busy it was difficult for them to monitor what the person had eaten or to encourage them to finish their meal. Staff were not available to supervise and provide support to people after they left the dining room. This meant some people who were mobile and walked along the corridors were unsupervised. We observed a disturbance taking place between two people who used the service outside of the dining area and the manager and compliance manager intervened to address the situation. On the ground floor one person had to wait 30 minutes to receive their meal as other staff were busy assisting other people to eat. We discussed this with the manager who told us the meal time was protected and all staff would be involved to assist people to eat where this was required. At the evening meal time we observed three relatives assisted their family member to eat.

Staff had a good understanding of safeguarding and knew how to report any concerns. They told us they would report any concerns to the manager. One staff member told us, "I'd report any concerns to the nurse or manager straight away." Staff were able to describe various types of abuse. They could tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. Records showed and staff confirmed they had completed safeguarding training. We saw the manager made alerts to the local authority and investigated all concerns.

Risks to people's safety had been identified and actions taken to reduce or manage hazards. Risk assessments were recorded in people's care records. The documents were individualised and provided staff

with a clear description of any identified risk and specific guidance on how people should be supported in relation to the identified risk. For example, from falls or pressure area care. Where an accident or incident did take place these were reviewed by the manager or another senior staff member to ensure that any learning was carried forward.

People were supported with their medicines safely. We observed part of a medicines round. A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

The medicines policy provided guidance for the use of 'when required' medicines which may be required when people were in pain, agitated or distressed. Guidance was available in people's care plans, which detailed the differing level of support needed by each person.

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the positive behaviour support team. Staff told us they followed the instructions and guidance of the positive behaviour support team for example, to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

Records showed that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their

mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

An up-to-date business continuity plan was in place to show how the service would continue to care safely for people in the event of an emergency. A senior member of management was always on-call and could be contacted at any time for information and advice. This indicated plans were in place to deal with emergency or untoward situations.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs and they were supported in their role. One staff member told us, "I've done lots of training." Another staff member commented, "I'm doing dementia care training on Thursday." A third member of staff said, "We do practical and e-learning training."

The staff training records showed and staff told us they received training to meet peoples' needs and training in safe working practices. There was an on-going training programme in place to make sure all staff had the skills and knowledge to support people and this included a range of courses such as, basic life support, dementia awareness, catheter care, syringe driver, verification of death, dignity and choice, equality and diversity, fluids and nutrition, wound care, pressure ulcer prevention, care planning and mental capacity.

Staff told us when they began working at the service they had completed an induction programme and had an opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. They said training consisted of a mixture of face to face and practical training. Support staff commented they received regular supervision from one of the home's management team every two or three months and registered nurses received supervision from the registered manager. One staff member told us, "The nurse does my supervision." Another member of staff commented, "I'm responsible for supervising support staff on the top floor." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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 procedure 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. 32 DoLS applications had been authorised by the relevant local authority. Records showed assessments had been carried out, where necessary, of people's capacity to make particular decisions. For example, with regard to their care. Staff said if a person refused support for example, with regard to their personal care or taking their medicine, they would offer alternatives or leave the person and try again later.

We discussed with the manager, the inappropriate use of a safety gate that was in place across a bedroom doorway. We were told it was to ensure a person who was confined to bed, but chose to have their door

open was not disturbed by people who may come in as they walked along the corridor. Records were also not in place that showed how the decision had been reached in the person's best interests and who was involved in the decision making. We were told the person's relative had requested for this to be put in place to keep the person safe. The manager agreed this need to keep a person safe in their bedroom should be considered as part of determining staffing levels rather than this form of physical restraint. The manager and nominated individual told us that this would be addressed immediately and they would look to purchase a sensor that would be placed at the person's door, rather than a safety gate. The sensor would trigger and alert staff if people went into the bedroom.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. One staff member told us, "We have a handover at the end of each shift. " Another person said, "Communication is good." A third person commented, "The nurse will hand over to the staff coming on duty."

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals such as General Practitioners (GPs), psychiatrists, a speech and language team (SALT) and dietician. Care plans reflected the advice and guidance provided by external professionals.

Relatives were kept informed by the staff about their family member's health and the care they received. One relative told us, "I had been poorly and received a call late one night. [Name] had taken ill and needed to go to hospital. I was too ill to attend but the staff kept me updated." Another relative commented, "Staff are very good at letting me know how [Name] is."

Systems were in place to ensure people received drinks and varied meals at regular times. Meals were well presented and people told us they had a choice at meal times. One person commented, "I enjoy the food." Another person told us, "I get plenty to eat, too much sometimes." A third person said, "The food's alright." We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. They explained how people who needed to increase weight and to be strengthened would be offered a fortified diet. Written information was available in the kitchen to inform any cook of the dietary preferences and specialised diets for people when the regular cook was not available. For example, diabetic, vegetarian and soft or pureed diets.

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid' balance charts to record the amount of food and drink a person was taking each day.

Some areas of the building had recently been refurbished and changes had been made to ensure it was stimulating and therapeutic for the benefit of people who lived there. Comments from relatives in a recent provider survey recorded, 'Decoration is good, corridors with seats', 'There's a tea room where you can sit with family and friends', 'It's more like home', 'It's more homely with the appearance of knic knacs' and 'The

finishing and the decoration is good.' Corridors and communal areas were bright and well-lit. There were areas of visual and sensory stimulation to help maintain the involvement and orientation of people who lived with dementia. The communal areas and hallways had decorations and pictures of interest, including memorabilia to help people reminisce. There were displays and pictures around the home to stimulate and remind people as they sat or walked around. There was appropriate signage around the building to help maintain people's orientation. Lavatories, bathrooms and bedrooms had pictures and signs for people to easily identify the room to help maintain their independence.

Good

Is the service caring?

Our findings

Staff appeared to have a good relationship with people and knew their relatives as well. People and relatives we spoke with said staff were kind, caring and patient. One person told us, "The staff are very good. They help me when I need it." Relatives were positive about the care provided. One relative told us, "I think [Name] is very well looked after." Another relative said, "Staff are fantastic." A third relative commented, "Everything's fine, the staff are lovely."

During most of the inspection there was a relaxed and pleasant atmosphere in the home. During the lunchtime on the top floor the atmosphere was less calm and tranquil in the corridor. Throughout the home staff interacted well with people. They were kind and caring and they spent time engaging with people and not only supervising them. As staff passed people on corridors they acknowledged them as they passed by.

People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. Good relationships were apparent and people were very relaxed. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance. Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff asked the person's permission before they carried out any intervention. For example, as they offered people drinks or assisted them to move from their chairs to the dining tables. Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner. Examples included, "Can I help you with that? (as a person ate a banana) and "Do you want me to take you to your room, for a lie-down?"

People's privacy and dignity were respected. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Staff received training to remind them about aspects of dignity in care and a dignity champion was also appointed from the staff team to promote dignity within the home. Information was also available in people's records that provided prompts about maintaining people's dignity. For example, one record for personal hygiene stated, 'Before commencing any care staff will explain to [Name] what the care is for to reduce feelings of anxiety and embarrassment.' Another record said '[Name] likes to look smart and tidy, they wear make-up occasionally.

Records were in place to inform staff when people were no longer able to express their views with regard to making their own choices over their daily lifestyle. For example, one person's record detailed, "[Name] sometimes likes a lie-in and will miss their breakfast." Other people told us they were able to decide for example, when to get up and go to bed, what they ate and what they might like to do. One person told us, "I like a long-lie in the morning." Another person said, "I go to bed when I want, I make all my own choices."

Care plans provided information about how people communicated. Examples in care plans recorded, '[Name] can verbalise their needs', 'Staff to encourage [Name] to express their views as they can communicate verbally' and '[Name] is able to inform staff if they are feeling unwell or in pain.' This

information was available for staff to provide guidance about how a person should be supported.

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

We observed the lunch time meal in the different dining rooms of the home. The atmosphere was quiet but staff were busy and staff tried to ensure people received a pleasurable dining experience. People sat at tables that were set with tablecloths and napkins. Tables were set for three or four and staff remained in the dining areas to provide encouragement and support or full assistance to people. People were offered juice and tea and coffee during their meal.

There was information displayed in the home about advocacy services and how to contact them. The manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people.

Good

Is the service responsive?

Our findings

People and relatives confirmed some activities were available. We were told the activities organiser had recently left recently and the post had been re-advertised. A programme of activities was available and these included pamper sessions, arts and crafts, sing-a-long and dominoes. The manager told us activities was an area that had been identified in the relatives survey as requiring improvement and action was being taken. An action plan was available that highlighted work that had been done and what still needed to be done as the activities post was not yet filled. The manager told us they planned to recruit two activities people so more cover would be available and also more ideas generated for the benefit of people.

During the day we saw people were stimulated and engaged as staff interacted with them on an individual or group basis. There was a lively atmosphere as music was playing downstairs in the hallway as people selected music of their choice and people sang along to it. Staff told us they all had the opportunity to spend an 'official half hour, to an hour' with people in the afternoon sitting with them and spending time with them. There was a large garden and people had the opportunity to sit out when the weather was fine. The home had been without a hairdresser but a new one had been appointed and they were waiting for clearance to start. It was planned they would visit weekly and a local member of the clergy visited regularly.

The manager told us of links with the community whereby local school children visited regularly and people loved their visits. One staff member told us, "[Name]'s face lights up when the children come in." 'Tea Pot' Thursday had also been introduced to encourage members of the local community to visit for a cup of tea and cake.

Seasonal events were celebrated throughout the year and entertainment took place. A summer fayre was advertised. Some relatives did say people had the opportunity to go out individually with the activities co-ordinator but they hoped people could go out for trips to the coast or countryside.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations were detailed and included information about peoples' progress and well-being. Reviews of peoples' care and support needs took place with relevant people. A relative commented, "I can read [Name]'s care plan at any time." Another relative told us, "I'm involved in meetings about [Name]'s care." A third relative said, "I requested [Name]'s door be kept locked. This immediately went into [Name]'s care plan and I signed on their behalf."

Other information was available in people's care records to help staff provide care and support. Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-

dated monthly. Charts were also completed to record any staff intervention with a person. For example, turning charts, where it was identified a person was at risk of developing pressure areas, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, the speech and language therapist was asked for advice with regard to swallowing difficulties and communication.

People's care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Social care plans were developed from this information. For example, one social care plan stated, '[Name] is not interested in television or listening to music. They will participate in painting or drawing.' Another care plan stated, '[Name] enjoys tidying tables and making their own bed.'

Monthly meetings were held with people who used the service and their relatives. The manager told us meetings provided feedback from people about the running of the home. A relative told us, "Relatives meetings take place." Meeting minutes for May 2017 showed items discussed included, 'Staffing, activities, forthcoming events, hair dressing and changes in management.'

People said they knew how to complain. People we spoke with said they had no complaints. A relative told us, "I had to make a complaint once and it was sorted out." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and we saw five complaints had been received since the last inspection and they had been appropriately investigated and resolved. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

The home had a manager who was appointed in April 2017 and they were in the process of registering with CQC. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The provider had displayed the Care Quality Commission's (CQC) rating of the service, including on their website, as required, following the publication of the last inspection report.

The manager and provider's representatives assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The management team were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The atmosphere in the home was lively and friendly. People told us the atmosphere was warm and relatives said they were always made welcome. The manager was enthusiastic and had introduced ideas to promote the well-being of people who used the service. Staff and people we spoke with were positive about their management and had respect for them. They told us the service was well led. They said they could speak to the manager, or would speak to a member of staff if they had any issues or concerns. They told us the manager was creating a staff team and morale had improved amongst staff. Staff and relatives said the manager was supportive and accessible to them. One relative commented, "The manager is very approachable." Another relative told us, "[Name], the manager is lovely." A third relative said, "The manger is 100% approachable." Staff members' comments included, "The manager is really approachable", "The manager is making changes" and "[Name] knows what's going on, they come out of the office."

Relatives were positive about the home and the changes that had taken place or were planned. They said they would recommend the home to other people. One person told us, "This is the best place for [Name]." Another person commented, "There has been a noticeable difference in the home since the new manager took over." A relative's comment in a recent provider survey stated, 'The manager is very approachable, cares about peoples' feelings and has made lots of good decisions about the residents in their care.'

The manager said they were well supported in their role by the provider and regional manager. They told us they had access to a range of care industry and related publications and kept up to date with best practice and initiatives. These included links with the Alzheimer's Society and the Tyne and Wear Care Alliance, an employer-led body that supports workforce development in the independent care sector.

Staff told us monthly staff meetings took place and minutes of meetings were available for staff who were unable to attend. One staff member commented, "We've just had a staff meeting." Another member of staff said, "Meeting minutes are displayed if you can't get there." Various staff meetings took place to ensure the home was well-led and communication was effective. A daily 'flash' meeting took place with the manager and heads of department to allocate work each day. Regular head of department meetings also took place, as did general staff meetings. Staff meetings kept staff updated with any changes in the service and to

discuss any issues.

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. A monthly risk monitoring report that included areas of care such as people's weight loss, pressure area care and serious changes in people's health status was completed by the manager and submitted to head office for analysis. Regular monthly analysis of incidents and accidents took place. The manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of re-occurrence.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The manager completed some daily audits such as a daily walk around the building to check the environment and check morale of staff and people who used the service. Monthly audits included checks on people's dining experience, medicines management, care documentation, training, kitchen audits, accidents and incidents and nutrition. Three monthly audits were carried out for infection control, falls and health and safety. A financial audit was carried out by a representative from head office annually. We were told monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the manager. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. A variety of information with regard to the running of the service was displayed on noticeboards in the home to keep people informed and aware and this included the complaints procedure, safeguarding, advocacy and forthcoming events.

A 'Resident of the day scheme' had been introduced whereby one person each day had all aspects of their care and support requirements reviewed by the heads of department to ensure the person was receiving person-centred care. For example, care needs, activities and menu preferences, care records and the person's bedroom would all be reviewed with the person to ensure they reflected the person's wishes and preferences.

The manager told us the provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and staff. A food survey had been completed in March 2017 to comment about the seasonal menus that were in place and to make any adjustments as required. Comments from other surveys showed that any comments that required action they were responded to and action taken. For example, the staff survey completed in March 2017 provided a written response to all staff comments that also showed what action was or was not required. A relative survey was carried out by the provider in May 2017. We saw the results had been analysed and feedback was available showing what action was to be taken as a result of the survey. For example, with regard to activities. Other relatives' comments included, 'Walking into Willowdene I knew [Name] would be well looked after. I have recommended Willowdene to other people looking for care for their family second to none' and 'First class service in all departments."