Willett Lodge Care Home Ltd

Willett Lodge

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

The inspection took place on 26 January 2016 and was unannounced. Willett Lodge is a nursing home that is registered to provide care and support for up to 20 people with a range of health needs, including dementia. At the time of our inspection, 18 people were living at the home. Willett Lodge is situated in a residential area of Worthing close to the town centre and seafront, with easy access to public transport. The home has a large sitting room, dining room, hall area and sun lounge. Bathrooms are accessible and equipped for people with limited mobility. Some bedrooms have en-suite facilities. There is a garden to the rear of the property and a decking area so that people can sit outside.

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 were supported to be safe by staff who had been trained to recognise the signs of potential abuse and knew what action to take if they suspected abuse was taking place. Risks to people were identified, assessed and managed appropriately. Accidents and incidents were recorded and monitored and, where needed, risk assessments and care plans were updated. Premises and equipment were managed to keep people safe. Environmental risks had been identified and assessed and safety checks undertaken as needed. There were sufficient numbers of staff on duty and when new staff commenced employment, checks were undertaken on their suitability to work in the care profession. People's medicines were managed so they received them safely by trained staff. The home was clean and hygienic and staff wore personal protective equipment when delivering personal care and serving meals.

Staff were trained in a wide range of areas so people received effective care. New staff undertook an induction programme and followed the Care Certificate, a universally recognised qualification. Staff received regular supervision and had annual appraisals. The requirements of the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards were understood by the registered manager and staff. Where required, decisions were taken in line with this legislation and best interest meetings held. People were supported to have sufficient to eat and drink and to maintain a healthy lifestyle. They had access to a range of healthcare professionals and services. People were encouraged to personalise their rooms with photos and ornaments that were important to them. The provider was in the process of redecorating the home.

People were looked after by kind and caring staff who knew them well. Staff cared for and supported people in a warm, friendly and reassuring way. One relative said, "They do over and above what they have to do, but they do it because they care". People were treated with dignity and respect and were encouraged to be involved in decisions about their care. Care plans were reviewed monthly and relatives were consulted and involved in care planning. Staff were trained to support people as they reached the end of their lives to enable people to have a comfortable and pain-free death.

Care plans contained comprehensive information about people and provided guidance to staff on how they wished to be cared for. Some care plans did not contain personal histories about people and the registered manager was in the process of completing these, in conjunction with people's relatives. A range of activities was on offer, with group activities or staff spending 1:1 time with people to engage in their hobbies or games. People were encouraged and supported by staff to go out into the community. Complaints were managed appropriately and, where necessary, appropriate action taken to prevent the risk of reoccurrence.

People were involved in developing the service and their views, together with their relatives, were obtained through annual surveys. Staff felt supported by the registered manager and there was an 'open door' policy so that staff could discuss any issues of importance to them. Relatives spoke highly of the registered manager and feedback was positive about the home overall. A range of quality audit systems was in place to regularly check on the quality of the care delivered and to drive continuous improvement.

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 protected from harm and staff were trained to recognise the signs of potential abuse and knew what action to take. Risks were managed appropriately.

There were sufficient numbers of staff on duty and new staff were subject to checks before they commenced employment.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

New staff undertook an induction programme and followed the Care Certificate. There was a range of training on offer which staff had completed and updated.

Staff understood the requirements and their responsibilities under the Mental Capacity Act 2005 and associated legislation and put this into practice.

People had sufficient to eat and drink and had access to a range of healthcare professionals and services.

People were encouraged to personalise their rooms to make them homely.

Is the service caring?

Good

The service was caring.

People were looked after and supported by kind and caring staff. They were treated with dignity and respect.

People were supported to express their views and to be involved in decisions about their care, as were their families.

Is the service responsive?

Good

The service was responsive.

Care plans contained comprehensive information about people to enable staff to build relationships and provide care appropriate to them.

A range of activities was organised for people, some were group activities and others were provided on a 1:1 basis between people and staff.

Complaints were listened to and managed appropriately. Where needed action was taken to prevent reoccurrence.

Is the service well-led?

Good

The service was well led.

People and their relatives gave their feedback about the service through annual surveys.

Staff felt the home was well led and the registered manager was approachable. Relatives spoke highly of the registered manager and staff.

There were systems in place to measure the quality of the service delivered and to drive continuous improvement.

Willett Lodge

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.

The inspection took place on 26 January 2016 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, we examined the previous inspection reports and we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which the service is required to send to us by law. We also took account of concerns raised as a result of a safeguarding investigation that was being managed by the local authority. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including four care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with two people living at the service. Due to the nature of people's complex needs, we did not ask direct questions. For some people, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the provider, registered manager, a registered nurse who was also the deputy manager and two senior care staff. After the inspection, we contacted three relatives to obtain their feedback about the home.

The service was last inspected in August 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People were protected from avoidable harm and a registered nurse told us, "It is important to make sure people are safe". We asked relatives if they felt their family members were safe living at Willett Lodge. One relative said, "Absolutely. I have no qualms about the care. They listen to my concerns about him too". Staff members had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse. Staff were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would let you guys [Care Quality Commission] know if I saw something". Another staff member said, "I would tell someone outside the home if the manager wouldn't do something, but I know they would".

We looked at the provider's incident and accident records and there had been 73 accident/incident forms completed in 2015. The most recent records showed that action was taken to minimise the chance of a reoccurrence. For example, one person had physically assaulted another person earlier in the year. The provider raised a safeguarding alert to the local authority. They subsequently participated in a multi-disciplinary meeting with social workers, mental health professionals and the person's GP to plan a course of action to prevent a reoccurrence. All accident and incident records contained a clear description of the event and indicated whether it should be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1995). Accidents and incidents records were also subject to a monthly audit in order to identify possible patterns or triggers. The registered manager told us that they would also make a referral to the local authority falls team if they identified people suffering multiple falls.

Risks to people were managed so that they were protected and their freedom supported and respected. Care records showed that people's risks had been identified and assessed appropriately. There was information and guidance for staff on how to manage people's risks safely and to mitigate future risks. One care plan showed that the person's risks had been assessed in tissue viability, mobility, moving and handling, medication, comprehension and communication. An overall risk summary had been completed and across the areas assessed, this person had been identified as at 'significant risk' and appropriate measures were in place. People's risks of developing pressure ulcers had been assessed. We asked the registered nurse what action they would take if people developed a significant pressure area. They told us that they would contact the GP and also ask for advice and support from a tissue viability nurse; a pain management plan would also be put in place.

We asked staff about their understanding of risk management and keeping people safe whilst not restricting freedom. One staff member said, "We have to make a decision in someone's best interests sometimes, but that's only when they don't know the risks they're taking". Another staff member told us, "Keeping people safe is important. Most of the people here have dementia, but they can still do some things for themselves".

Premises and equipment were managed to keep people safe. Potential risks had been assessed in the environment. A sensor and alarm had been fitted to the stairs, so that if people used the stairs unaccompanied by staff, then an alarm would sound and alert staff. Radiator covers had been fitted to

protect people against the risk of burns. Personal emergency evacuation plans were in place for people, so that staff knew what action to take in the event of fire, power failure or flood.
Maintenance and equipment checks had been undertaken during 2015 for gas appliances, lift servicing, environmental health, clinical waste, household waste, Legionella testing and hoists. We observed that light bulbs were not functional in chandeliers in the dining room, sitting room and hall areas, although the areas were still adequately lit. The registered manager had purchased new bulbs which were to be fitted. However, the provider said that the light fittings were not operating correctly so that light bulbs continually needed replacing. The provider had ordered new light fittings and showed us documentation to confirm this.

There were sufficient numbers of suitable staff to keep people safe and meet their needs. A relative felt there were sufficient staff on duty and said, "Lunchtimes can get a little hectic, but all the residents are cared for. It always feels like there's a lot of staff here doing all the work". We asked staff the question, "Do you think there are enough staff to care for people consistently well?" One staff member said, "I think there are enough staff. We tend to have three or four on in the mornings and three in the afternoon and evenings. There's only two on at night though". Another staff member told us, "It's okay, yes. Some days are busier than others, but there are enough of us I think".

We looked at the staff duty rota for the period between 14 December 2015 and 10 January 2016. The rota showed that staffing levels ranged from four to five care staff on duty in the daytime and evenings, plus the registered manager and deputy manager. There was also a registered nurse on duty at all times, in addition to one member of care staff at night. Agency staff were used during the period in question. For example, five shifts were covered by agency staff in the week commencing 14 December 2015, totalling 51 hours of care.

We asked how safe staffing levels were established by the provider. The provider did not use a formal tool to assess the changing care needs of people and calculate staffing levels accordingly. Instead, the registered manager reassessed staffing levels according to occupancy rates and changes identified in people's care needs. A registered nurse told us that care staff could be used flexibly and gave an example that if a person was taken ill, then care staff would provide a higher level of support to that person. We asked the registered manager about staffing levels during the night and they referred to the night staff saying, "They do seem to manage quite well". We were told the staffing levels were adequate for the care needs of people and that night staff could contact the registered manager directly and call on staff from one of the provider's other homes across the road if urgently required. The majority of people had sensor mats placed by their beds, so that night staff would be alerted if people were moving around. Our examination of accidents and incidents occurring at the home confirmed there was no increase in falls or accidents at night, which would have indicated a possible shortage of staff.

Appropriate checks were undertaken before staff commenced employment. Staff files showed that criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including character references, interview notes and signed Working Time Directive opt out forms in staff files.

People's medicines were managed so they received them safely. Medicines were ordered, stored, administered and disposed of appropriately. Medicines were stored in a secure medicines trolley and any that required refrigeration were kept in a fridge dedicated to that purpose. We observed medicines being administered by a registered nurse at lunchtime. The registered nurse checked the Medication Administration Record (MAR) for each person before administering their medicine. Medicines were dispensed from a monitored dosage system into a dosset pot, which was handed to the person. The

registered nurse checked with people whether they had any pain and wanted any painkillers. The registered nurse waited patiently with people whilst they took their medicines. For example, one person was finishing their lunchtime sandwich and was not rushed to do this before taking their medicine. The registered nurse ensured that the medicines trolley was locked when unattended. Only registered nurses administered medicines and the registered manager undertook competency checks to ensure that nursing staff administered medicines safely. We observed the registered nurse testing one person's blood sugar levels to ensure their diabetes was managed safely. The registered nurse said to the person, "[Named person] which finger will you let me try?" The person was happy to have their blood tested and complied with the request. We checked the stock levels of some medicines. The medicines were kept securely and stock levels tallied with those recorded in the register.

The home was visibly clean and hygienic. Staff wore personal protective equipment whilst delivering personal care to people and when assisting people with their meals. Daily room checks were undertaken and records were kept on the back of people's bedroom doors. These showed when staff had completed the daily check of the room, which also included monitoring of people's care plans and that people had a sufficient supply of toiletries.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. A relative referred to staff and said, "There were a few I wasn't sure about, but the ones they have there now are much better. They all know the residents well". We spoke with staff about their experiences of induction following the commencement of employment. One staff member told us, "I thought it was good. I learned a lot". New staff undertook the Skills for Life Care Certificate covering 15 standards of health and social care. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

We spoke with staff about the training opportunities on offer. One staff member said, "The training is good and there's quite a lot of it". Another staff member told us, "Yes, we get training every year which helps a lot. I've done stroke awareness training recently". A registered nurse told us about training they had received in dementia, diversity, health and safety, moving and handling, end of life care, mental capacity and data protection. All training was delivered by an external training organisation.

We asked staff how they were formally supervised and appraised by the provider. All staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member said, "I think it's open and honest. Yes, I can say what I want". Another staff member told us, "We have that, yes. There's no problem there". A registered nurse confirmed they had supervisions with the registered manager and that a representative from an external training organisation also met with them to discuss any training needs or additional support they required. The staff supervision planner and five supervision and appraisal records we checked confirmed that supervision sessions and yearly staff appraisals for all staff had been undertaken or was planned, in line with the provider's policy. Staff meetings were also held and a registered nurse confirmed that one had taken place just before Christmas. Staff meetings were held monthly and the registered manager had circulated detailed minutes to staff. Staff meetings covered areas such as training, medicines and infection control.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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. We asked staff about issues of consent and their understanding of the MCA. Some staff had undertaken recent training in this area. All had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. People's care plans included capacity assessments. One person's care plan referred to their ability to consent and stated, 'Monitor – views of mental health team would be that she would be unable to make important decisions'. The care plan included an assessment of the person's communication and comprehension and stated, 'Encourage [named person] to make decisions as much as possible regarding

how she spends her days'.

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). Some staff members could explain the meaning of DoLS for the people they were supporting. One staff member told us, "We do need to make decisions in people's best interests sometimes if they don't have mental capacity and don't understand risks". Another staff member told us, "I think the MCA is about letting people do things for themselves if they can". The registered manager had completed capacity assessments for people living at Willett Lodge and had applied for DoLS authorisations as needed. One application for DoLS had been recently authorised by the local authority, but the majority of applications were still in the process of being reviewed.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. A relative told us, "Food's lovely. He eats things he never used to eat at home and they do try and do different things. There's plenty to eat and drink". Another relative felt that the food was, "A little bit hit and miss". They added that they had been invited to a family food tasting session which the provider had organised. As a result of this session, a new menu had been created which incorporated the views and preferences of people and relatives. The relative went on to tell us, "Sometimes it doesn't look healthy, but Dad likes it". People were asked to select what they would like to eat from a menu the day before. Their choice was then checked again on the day in question, to see that people had not changed their minds and wanted a different meal.

On the day of our inspection, the lunchtime choice was either pork pie, coleslaw, tomatoes and boiled potatoes or fish, mashed potato and baked beans. People appeared to enjoy the meals on offer and one person chose to have a sandwich instead. People particularly enjoyed the dessert, a choice of chocolate cake or ice-cream. Some people ate in the dining room, whilst others chose to have their meals brought to them on trays and ate in the sitting room. People were asked if they wished to wear a protector to keep their clothes clean whilst eating and staff also checked with people if they needed support to eat their meal. Where people did require assistance from staff, we observed staff sat next to them and engaged in conversation whilst helping people to eat. Drinks were freely available and everyone had a drink to hand. People were also asked if they would like a hot drink with their lunch. We observed one person was offered an alternative lunch when they stopped eating. One staff member said to the person, "[Named person] just try this?" to which the person responded, "I've tried it and I don't like it". The person then said they wanted to go home. However, we observed that if staff left the person alone, that they carried on eating and finished the meal, when the staff member was not looking. Some people ate their meals off brightly coloured, plastic plates. Staff told us that coloured plates helped people with a visual impairment to locate the food more easily and enabled them to eat more independently.

People were weighed every month so that any increase or decrease in weight could be monitored and appropriate action taken. For example, one person had been assessed as underweight according to their care record. Where people had been assessed as at risk of malnourishment, the kitchen staff prepared meals that included full fat milk and dairy products, as well as food supplements, in an effort to increase people's weight. Care records showed that people had been assessed using a combination of their height, weight and body mass index, using the Malnutrition Universal Screening Tool, a tool designed specifically for this purpose. Special diets were catered for and one person who had swallowing difficulties had been assessed by a speech and language therapist who had recommended a soft, pureed diet.

People were supported to maintain good health and had access to a range of healthcare services and professionals. One relative told us, "If he's not well, they'll ring me and tell me. They changed one of his

tablets last week and they told me". We looked at three care plans in order to ascertain whether people's health care needs were being met. The provider involved a wide range of external health and social care professionals in the care of people. These included speech and language therapists, community dieticians and the local authority DoLS team. Advice and guidance given by these professionals was followed and documented. One care record showed a dental treatment plan for the person, an optical assessment, hospital discharge letters, GP notes and blood pressure readings.

People were encouraged to bring items of furniture and personal effects to decorate their rooms when they came to live at the home. The provider had encouraged relatives to help their family members with this to give bedrooms a personalised and homely feel. Some rooms contained photos and ornaments that were special to people, however, other rooms were similarly furnished with identical bedcoverings and armchair upholstery. People's doors had their names and photos displayed and some doors were painted to reflect the interests of the particular individual. For example, one bedroom door had a picture of a London bus on display and the occupant had once been a London bus driver. Another person was a keen poppy seller for the Royal British Legion and had pictures of poppies on their door. Communal areas of the home had wipe-clean flooring, but all bedrooms were carpeted. The provider said they were focusing on redecorating the home at the moment and said, "We do paint the home, but you do get scuffs". People could choose the colour they wanted their room to be decorated and could pick their own curtains when they came to live at the home.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. One relative told us, "Staff are very patient and caring. You never hear them shouting at anyone. It's more like a family to us now". They went on to say, "It's little things that help me. He gets upset when I leave. Staff stay with him then and reassure him". They said that if they were unable to visit their family member in person then, "I can speak to him on the phone". Another relative spoke positively about the care staff and said, "The way they understand the residents and try and make their time as pleasant as possible". They confirmed that staff delivered care promptly. Another relative described what happened when their family member was admitted to the home. They explained, "They welcomed him in. It was his Birthday the day after and they organised a cake". They referred to the staff and said, "These ladies couldn't do more. They shave him and keep him clean. I visit twice a week and it's not just with Dad, it's everybody. Staff know all residents really well. It's so different from what I imagined and it's all so lovely".

We observed care in communal areas at lunchtime and throughout the day. Care was safe and appropriate, with adequate numbers of staff present. We observed excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting people. There was a high level of engagement between people and staff and people, where possible, felt empowered to express their needs and receive appropriate care. It was evident throughout our observations that staff had enough skill and experience to manage situations as they arose and care given was of a consistently high standard. For example, at lunchtime and throughout the day, staff wore appropriate personal protective equipment, such as aprons. People were asked if they would like music playing whilst they ate their meal.

Staff were kind, friendly and caring with people. We observed a registered nurse was very reassuring with one person when they became upset and wanted their mother. The staff member chatted with them and steered the conversation onto another topic, so the person's thoughts were distracted and they became calm again. People were encouraged to get out of bed every day and to engage with other people and staff. The registered manager said it was better for people to engage in physical activities as much as they could and said, "It's better for their chests", referring to the risk of chest infections for people who were immobile.

Some of the care plans we looked at contained both life histories and social assessments. They had been compiled in conjunction with people and their families where possible. However, the majority did not have such detailed information which staff could use to help build relationships, for example, people's previous occupations and hobbies. We discussed this with the registered manager who agreed this was an area for improvement.

People were supported to express their views and to be actively involved in making decisions about their care, treatment and support. A registered nurse explained the importance of allowing people to make choices and added that it could be challenging sometimes. They gave an example that if someone had soiled themselves and would not allow staff to help clean them up. The registered nurse went on to say that they would always offer a change of staff to people, as this could often result in a positive outcome for the person. All care plans and risk assessments were reviewed monthly and signed by staff. There was evidence

that people and their relatives had regular and formal involvement in care planning and risk assessment. People's views were sought on their care planning so there were opportunities for care plans to be altered if they did not reflect the person's care needs accurately. People or their representative's consent was also sought on a variety of issues, including the sharing of information with external agencies and photography for identification purposes. A relative told us, "I see his care plan every time it's updated" and confirmed that consent was sought when their family member had a 'flu jab. Another relative had stated in feedback received, 'I am always updated in Dad's care, but not involved in planning all the time. I do not expect to as they are the experts'.

We asked staff how they supported people to maintain their dignity and privacy. One staff member told us, "We treat them as people". Another staff member said, "We have the time to get to know them and find out what they like". Our observations at inspection confirmed this. People were addressed by staff by their preferred name. Sometimes this was their first name, but one person preferred to be addressed as, 'Mr [surname]'.

People were supported at the end of their life to have a private, comfortable, dignified and pain-free death. Staff received training in end of life care and also received advice, guidance and support from a local hospice. There was no-one at the home currently receiving end of life care. The registered nurse said that people could spend their last days at the home and explained, "We do anything that is needed to keep people comfortable".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One relative told us, "He's doing so well now. Eats everything and anything. He's walking with a frame now and it's all down to them". Care plans and daily records were legible, relevant and up to date. They contained detailed information about people's care needs, for example, in the management of risks associated with challenging behaviour and pressure area care. Some care plans also contained information about people's personal histories and likes and dislikes. People's choices and preferences were documented. The daily records showed that these were taken into account when people received care, for example, in their choice of activities. Care planning and individual risk assessments were reviewed monthly.

People's needs were assessed appropriately and care and treatment was planned and delivered to reflect their individual care plan. One care plan referred to personal care and stated, 'Requires assistance of one [member of staff]. Can become agitated when being assisted with personal care and has had episodes of physical aggression towards staff'. The guidance for staff stated, 'Gain consent from [named person] before commencing any interventions'. Staff confirmed that this guidance ensured they could provide care for this person appropriately. Care was person-centred and focused on the individual's personal needs, wants, desires and goals, so they were central to the process. We asked staff what they understood by the term 'person-centred care'. One staff member told us, "If I have a jug of orange juice, it doesn't mean everyone should have a glass just because it's in my hands. People are all different and have different needs". Another staff member said, "We make an assessment when someone comes to the home, so we know what they like and don't like".

The registered nurse said that they had a "brainstorming meeting" with staff every day at 11am. This was an opportunity for staff to discuss people's care, for example, their mood, any pressure areas and nutrition. The registered nurse explained the meeting was about, "Anything I need to know" and said that any health issues could be addressed promptly saying, "I can get the GP and inform the family". This member of staff provided an example where one person had been very sleepy in the morning. As a result, their GP was called and their medicines adjusted and the person's condition improved. In addition to the 11am meeting, there were handover meetings between shifts where staff could meet and discuss people's care needs and support. This ensured that people's most up-to-date care needs were met.

Relatives told us about the activities on offer. One said, "A lady comes in and does exercises" and "There was a nice do at Christmas and everyone joined in with the singing". They referred to their family member and said, "We can take him out and stay out all day if you like". Another relative said there were, "Lots of group activities and they have family fun days too. When people want to go out, they can".

A range of activities was organised for people living at Willett Lodge and we were given a copy of '2016 – Dates for your diary'. Activities for January included a visit from a chiropodist and hairdresser, exercise therapy every Wednesday and Friday, music for health fortnightly and a massage therapist visited monthly. On the day of our inspection, a person had come in to give hand massages to people which they enjoyed. They had been accompanied by their black Labrador guide dog who was also very popular and enjoyed

being fussed and stroked by people. People were also encouraged to go out into the community and a taxi had been organised to take one person into town to buy some make-up. However, they later changed their mind and decided they did not want to go out after all, a decision which was respected. Staff told us that, "Some people won't go out at all". Sometimes group activities are not always meaningful for people living with dementia, so people were supported by staff to engage in activities on a 1:1 basis, for example, with knitting or to play board games. On the day of our inspection, a 'movie night' was planned. This involved re-arranging all the chairs in the sitting room in an auditorium style way, so people sat in rows to look at the large television screen. People were offered the choice of a drink, including alcohol if they wished, with snacks and nibbles to eat while they watched the film.

Complaints were listened to and managed appropriate in line with the provider's complaints policy and procedures, which were displayed in communal areas. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. We looked at the complaints log and there had been three formal complaints made in the past year. The complaints had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties, with an action plan where necessary, to prevent reoccurrence. A relative told us, "For me and my family, we're quite happy. If I wasn't happy, I would tell the manager".

Good

Is the service well-led?

Our findings

As much as they were able, people were actively involved in developing the service. Residents' meetings were held and records confirmed this. Questionnaires were sent to people and their representatives and 10 responses were returned. The questionnaire asked for people's opinions of the home and asked them to rate from 'poor' through to 'very good'. People were also asked for their feedback on the care provided, the strengths of the service and any areas which could be improved. Overall the results were positive. One relative commented, 'Since [named registered manager] took over, the home has continued to improve and communication is perfect'. Another relative said, 'Have noticed that the level of cleanliness has improved and the garden is looking lovely too. Thanks for all the hard work!' A relative we spoke with after the inspection told us, "Overall I've been very, very impressed from the moment we contacted them. Dad didn't want to move …. but he needed a care home. We had a look and we couldn't have asked for more" and added that they looked at three care homes, then chose Willett Lodge.

We asked staff about the vision and values of the home. One staff member said, "I think that it's a home from home". Another staff member told us, "We need to keep people safe, but it's also people's homes".

We asked staff if they thought the home was well led. One staff member told us, "I think it is. The manager is really approachable". Another staff member said, "I think it's well run, yes". Staff members confirmed to us that the registered manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence. We asked the registered manager for their views on the culture of the home and they said, "I want this to be the best, that we give the best care and it's person-centred. We want them to be happy and safe and well cared for, then my job will be done". The registered manager had been in post for 18 months and told us, "I'm loving it. I learn something new every day". They felt the provider had been very supportive.

Relatives spoke highly of the registered manager. One relative told us, "[Named registered manager] has made a lot of difference and she's improved it a huge amount" and, "The best part is the manager. She makes herself totally available for family and residents". A further comment was, "We've really felt comfortable with [named registered manager] in post. Everything is actioned straight away".

Robust quality assurance and governance systems were in place to drive continuous improvement. Checks were made on the environment, medicines, privacy and dignity, staff working and infection control. Accidents and incidents were analysed to identify any trends or patterns. In addition to these monthly checks, the provider also employed the services of an external consultant to provide an objective overview on all aspects of the service provided. Where action was identified as needed, records confirmed the steps to be taken. Family and friends of residents were asked for their feedback through an annual survey.