

Scimitar Care Hotels plc

Woodbury Manor

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 inspection took place over two days on 10 and 11 January 2017 and was unannounced. At our last inspection we found four breaches of regulations 11, 12, 16 and 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This related to assessing people's capacity and decision making ability, emergency evacuation in case of fire, responding appropriately to complaints and staff not receiving regular supervision and appraisal. At this inspection we found that the provider had addressed these issues.

Woodbury Manor is a residential care home that provides care and support for 60 people aged over 65, some of whom have dementia. The home does not provide nursing care. It has three wings. Cedars, which provides care and support to 22 people living with advanced dementia. Maple and Woodbury provide care and support for people who are elderly frail and may have a diagnosis of early stage dementia. At the time of the inspection the service was supporting 51 people.

There was a registered manager in place who had been in post for 11 months. The registered manager was present throughout the inspection. 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.

There were detailed risk assessments in place that provided staff with clear guidance on what the risks were to that individual and how identified risks could be mitigated. Risk assessments were tailored to each individual. Risk assessments were reviewed and updated regularly.

There was a system in place if people were at risk of developing pressure ulcers. All people living at the home were assessed each month and appropriate referrals made if there were any concerns.

Procedures relating to safeguarding people from harm were in place and staff understood what to do and who to report it to if people were at risk of harm. Staff had an understanding of the systems in place to protect people who could not make decisions and were aware of the legal requirements outlined in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS).

Care plans were person centred and reflected individual's preferences. Care plans had been signed by people. Where people were unable to sign, they had been signed by relatives.

Medicines were well managed by the home. People received their medicines on time. Medicines storage was appropriate and secure and there were regular audits of medicines.

Accidents and incidents were documented and any follow up treatment was recorded.

People were supported to ensure that they had enough to eat and drink to meet their nutritional needs.

Staff were aware of specialist diets and people's needs relating to this.

The provider had ensured that all staff employed had received appropriate checks before commencing employment.

The provider encouraged learning and development. Training was updated regularly and monitored by the manager. Staff had regular supervision and annual appraisals that helped identify training needs and improve the quality of care.

There were activities provided for people and people were involved in choosing what activities they wanted each month.

There was a complaints procedure in place which people and relatives had access to. Complaints were responded to and resolved in a timely manner.

People and their relatives felt that staff were kind and caring.

Audits were carried out across the service on a regular basis that looked at things like, medicines management, health and safety and the quality of care. There was a complaints procedure as well as incident and accident reporting. Surveys were completed with people who used the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

There was a clear management structure in place. People who used the service and staff were aware of the lines of accountability. This allowed for good communication and an atmosphere where staff and people felt able to appropriately challenge each other and discuss ideas that led to improvements in the quality of care.

There were systems in place to identify maintenance issues. Staff were aware of how to report and follow up maintenance.

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. Staff were able to tell us how they could recognise abuse and knew how to report it appropriately.

Risk assessments identified all known risks and provided staff with guidance on how to mitigate known risks.

People received their medicines safely and on time. Medicines were appropriately documented and staff were knowledgeable about the medicines they were administering.

Accidents and incidents were documented and follow up care recorded. Staff knew what to do if someone had an accident or sustained an injury.

There were systems in place to ensure safe staff recruitment.

Is the service effective?

Good ●

The service was effective. All staff received regular supervision and appraisal.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS).

People received a good choice of different foods. Food was appetising and there were generous portions. There was detailed guidance for staff to ensure that people with specialist dietary requirements were catered for appropriately.

People's healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

Is the service caring?

Good ●

The service was caring. People were supported and staff understood individual's needs, likes and dislikes.

People and relatives were positive about the home and felt that staff were kind and caring.

People were treated with respect and staff maintained privacy and dignity. Interactions between staff and people were generally positive.

People's religious needs were taken into account and provided for.

Is the service responsive?

Good ●

Care plans were person centred and tailored to each person. Care plans gave clear information on people, their needs and how they wanted their care delivered. People and relatives were involved in planning their care.

There were activities provided by the home that people had input into choosing at monthly residents meetings.

The home was dementia friendly and had adaptations and decorations in place to promote independence.

People were encouraged to maintain contact with relative and friends.

People knew how to make a complaint. There was an appropriate complaints procedure in place.

Is the service well-led?

Good ●

The service was well led. There was a positive and open culture that encouraged best practice and this was encouraged by management.

Systems were in place to ensure the quality of the service people received was assessed and monitored.

There was good joint working with healthcare professionals and healthcare professional were positive about their communication and relationship with the home.

Woodbury Manor

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 10 and 11 January 2017 and was unannounced.

Before the inspection we reviewed notifications and other information that the home had sent to us. We reviewed the action plan that the provider had sent to us regarding issues that had been found at the last inspection.

This inspection was carried out by two inspectors and an expert by experience that had experience of dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A second expert by experience contacted relatives by telephone.

We undertook general observations and used the short observational framework for inspectors (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 23 people who used the service, nine relatives, nine staff and one healthcare professional that was visiting the home at the time of the inspection.

We looked at seven people's care files, including care plans and risk assessments, 10 staff files and 38 people's medicines records as well as other paperwork held by the home.

Is the service safe?

Our findings

People told us that they felt safe at the service. People said, "Yes very much so, there is always someone around," "Yes, I am always well fed and all my needs are taken care of. There is always someone around that knows what they are doing" and "Yes, this place is nice and warm. The people here are lovely." Relatives were positive about people's safety and said, "Yes very much so. She has no steps to go up so she doesn't fall over here. I feel she is very safe" and "We are comforted and relieved that we can trust that they will look after her."

Staff were able to explain how they would keep people safe and understood how to report it if they thought people were at risk of harm. There were notices in the staff room telling them who to contact if they needed to report abuse. People told us, and we saw, that safeguarding was discussed in resident's meetings and both people and staff were encouraged to report any concerns if they needed to. The service's safeguarding policy was available and accessible to staff. Staff training records showed that staff had completed training in safeguarding. One staff member told us that safeguarding was, "To make sure that the residents' are protected from abuse and discrimination. I would go to my line manager or the CQC." Records showed that staff received training during induction and this was refreshed annually.

Staff understood what whistleblowing was and how to report concerns if necessary. Staff told us that the provider and registered manager actively encouraged people to raise concerns around safeguarding and that protecting people was part of the homes values.

Risk assessments detailed all known risks associated with people's health and support needs. Generic as well as individualised risks were assessed and guidance and clear direction was provided to reduce or mitigate risks to ensure people were kept safe from harm. All risks identified were graded as low, medium or high. Each risk was documented on a separate page and colour coded according to the level of risk. Examples of risk assessments that had been completed included diabetes, epilepsy, pressure sores, choking, behaviours that challenge, falls and swallowing difficulties. All risk assessments outlined the area of concern, the risk or hazard and the control measures in place. Each risk assessment was personalised to the needs of the person and the effect of the risk on that person.

At our last inspection we found that the home was not assessing people with regards to skin integrity. At this inspection we found that the home was appropriately documenting and assessing people's needs. The home assessed people's potential for developing pressure ulcers by using the Waterlow scale. The Waterlow scale is a specific way of estimating the risk to an individual of developing a pressure ulcer. If an individual is classed as medium or high risk their pressure mattress suitability is re-assessed. Records showed that Waterlow assessments were completed each month for people. Where a higher risk was identified, people were referred for further assessment for appropriate equipment to a tissue viability nurse. One person who was at risk of pressure sores, had guidance that they should be re-positioned every two to three hours during the day and every four to six hours during the night. Records confirmed that this was happening.

The home had a clear medicine administration policy which staff had access to. People's medicines were

recorded on medicines administration record (MAR) charts and used the biodose pack system provided by the local pharmacy. A biodose pack provides people's medicines in a pre-packed plastic pod for each time medicine is required. This includes tablets and the correct dosage of liquid medicines where required. It is usually provided as a one month supply. We checked MAR charts for 38 people for December 2016 and January 2017. People's medicines were given on time and there were no omissions in recording of administration.

We observed three medicines rounds throughout the inspection. Staff administering medicines had protected time to ensure that they were able to safely administer people's medicines.

The home had a medicines room that that was secure. The medicines fridge was clean and used only for the purpose to store medicines. The provider had installed a cooling system in the medicines room to ensure that medicines were stored at the correct temperature. Room temperatures and fridge temperatures were recorded on a daily basis.

Each person had a detailed medicines profile which was a one page document. This included information on people's allergies, the medicine they were currently prescribed including any 'as needed' medicines. As needed medicines are medicines that are prescribed to people and given when necessary. This can include medicines that help people when they become anxious or require pain relief. Where people had 'as needed' medicines, there was detailed guidance on what the medicine was for and in what circumstances these should be given. MAR charts detailed when these medicines had been given and the reason why. Where people had an allergy to a specific medicine, there was a risk assessment in place.

The home had appropriate storage for controlled drugs. There was a separate controlled drugs cabinet. Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. There were detailed administration records for people that received controlled drugs.

Where specific medicines were not appropriate to be in the biodose packs, these were clearly labelled with the person's name and kept in separate sections in the medicines cabinet. Homely remedies were stored separately in a locked cabinet. Records showed when people had received homely remedies and what they had been given for. We saw that the GP had authorised specific homely remedies to be used within the home. This included remedies for coughs, colds and constipation.

There were sufficient staff on duty to meet people's needs. We saw, and rotas confirmed that in the dementia wing there were six staff including two senior staff that worked from 08:00 until 21:00 and in the non-dementia wing there was six staff including a senior that did the same shift. At night there were six staff, including one senior that covered the home. Relatives told us, "I visit at the weekends and there are enough staff" and "Yes, there are always enough staff." One person said, "I don't know the numbers but there are a lot of them walking around all the time. It is the same at the weekend." However, other people told us said, "There doesn't seem to be enough. At busy periods of time you have to wait a long time to get seen. It can be up to 30 minutes' wait," "No I don't think so, they could do with a few more" and "No certainly not. The staff are not supervised all the time. On occasions, you have to wait a while especially at medication time. If you need to go to the toilet you have to wait a long time and they can't tell you how long they will be." During the inspection we observed a relaxed atmosphere, staff were not rushed and people received help when it was asked for.

Records showed that the home completed a dependency assessment for each person on a monthly basis

and submitted the results to the provider's head office. A dependency assessment looked at the level of support a person required throughout the month and allowed the home to adjust its staffing levels accordingly. The registered manager told us that the home was well staffed and she was able to put more staff on duty if a person's needs increased.

We looked at ten staff files and saw that the service had safe and effective systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK. Eligibility to work in the UK was monitored by the providers HR department and the home was informed of any queries or updates on visa status that were required. Any gaps in employment that were identified as part of the recruitment process were discussed with the staff member at the interview stage of the process.

The home had two hoists for moving and handling. There were up to date records of hoist maintenance. At our last inspection we found that people did not have individual slings based on their weight and needs. At this inspection we saw that the provider had purchased individual slings for people that required them. Slings were appropriately labelled with people's names. Staff were able to tell us which sling belonged to which person, as well as what type of sling the person was using.

Accident and incident records documented a detailed account of all accident or incidents that had occurred; actions taken, the date and time of the incident and a completed body map which indicated the area where the injury was sustained. A 36 hour report form was also attached to the records, which detailed monitoring and follow up checks for the person. An accident overview was in place which the registered manager used to note any patterns or common issues. The overview detailed all accidents or incidents that had occurred and details of the number of hospital treatments, doctor's treatments, district nurses treatments and no treatment required as a result of the accident or incident.

Each person's room had a call bell system in place. We tested the response time in one of the bedrooms if a person needed help. Two staff responded within 15 seconds of the bell being activated. There was an electronic record of when call bells were activated and how long it took staff to respond. This was monitored by the registered manager. This allowed the registered manager to recognise patterns or if a person was requiring a higher level of care.

At our last inspection we found that people living at the home had not had their needs assessed for what type of support they may have required in case of fire. At this inspection we found that the provider had addressed this issue. There were detailed plans and risk assessments for each individual in case of emergencies within the home. Each person had a personalised fire evacuation plan (PEEPS) which the staff were aware of, including manual handling directions and how many staff would be needed to safely evacuate that person. PEEPS were reviewed monthly and updated if there were any changes. Records showed regular testing of the fire alarm systems and fire drills.

The home employed a maintenance person. Staff were aware of how to report any maintenance issues. Records showed when a maintenance issue had been identified and actioned. This was signed off by the maintenance person and checked on a daily basis by the registered manager.

The home was clean and tidy on the days of inspection and we observed cleaning staff maintaining the cleanliness of the home throughout the two days. One staff member commented that the cleaning staff, "Do a dazzling job." Relatives also told us that the home was always clean and bright and "Never smells."

Is the service effective?

Our findings

At our last inspection, we found that staff were not receiving regular supervision and staff had not received an appraisal for two years. At this inspection we found that the provider had addressed this issue. All staff files we looked at had records of regular supervision as well as an annual appraisal. New staff had a booklet within their file which ensured that supervision was provided in the first four weeks, eight weeks and then 12 weeks as part of their probation. After probation a second supervision and appraisal booklet was added to the file and confirmed that staff received supervision three times a year and the fourth time was an annual appraisal. Supervisions covered areas such as settling into role, feeling competent in their role, any issues or concerns and training needs.

New staff members had an induction programme record on file. This covered areas such as holiday pay, accident procedures and timesheets. Mentors allocated to new staff were also required to complete a mentors induction checklist which covered introduction to residents, communication, personal hygiene, rooms, eating, promotion of continence and pressure area care. One staff member said, "I think that the induction was good. I was happy with my mentor. They showed me everything and if I didn't understand I could always ask. It is very supportive there."

Records showed and staff told us that they were provided with training to enable them to carry out their role. Training records showed when staff had completed training and when they needed to refresh specific training such as, safeguarding, manual handling and health and safety.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the 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.

We checked whether the provider 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 our last inspection we found that there was no information on people's capacity and the decisions that they were able to make in relation to their care and day to day activities. There were no best interests meetings in place and people had not signed their care plans. Although people that required a Deprivation of Liberty Safeguard (DoLS) had been identified, these had not been applied for. At this inspection we found that the provider had addressed this issue.

There were 29 DoLS authorisations in place for people. Where a DoLS had been granted there were timescales for review documented. Three people were awaiting the outcome of a DoLS application and 19

people did not require a DoLS. The registered manager had informed CQC of all applications and authorisations as per the legislation.

Mental capacity assessments were seen in all care files that were looked at. Assessments were personalised according to the person and detailed the areas in which decisions needed to be made in the person's best interest. Examples of decisions that had been made included, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), receiving care, medicines, deprivation of liberty and the use of electronic monitoring devices. Where best interest decisions had been made a summary of issues, discussions and decisions made was recorded. Each care plan contained a consent to care document which was signed by the person or their relative where appropriate.

There were lists in the kitchen of people who required specialist diets, such as mashed, pureed or vegetarian food as well as information regarding people that were diabetic. We spoke with the chef who was knowledgeable about what types of foods could and could not be given to someone that was diabetic.

People confirmed they received a choice of meat or fish and if they did not want either of those options they could ask for an alternative. We observed one person who asked for an omelette and was provided with this. The home had a four week menu plan that was displayed in the main dining room. People said, "It [the food] is always lovely. There is a menu and you can pick whatever you like. They always offer you a drink throughout the day," "I really enjoy the food, it's nice and tasty. There are a few choices you can pick from" and "I am a vegetarian and they give me a lot of sandwiches and lots and lots of fish. I wish there was more choice." People's care plans stated likes and dislikes with regards to food and drink.

For one person that required a specialist diet their care plan and risk assessment detailed actions staff needed to take to ensure that risks were mitigated. The person's care plan stated 'Ensure [name of person] is sitting upright and is alert prior to starting to assist with meals and drinks. Pureed diet, small teaspoons only' and 'Pureed meal to be presented in two halves. When [name of person] finishes first plate to wait five minutes and then give second plate.' This was observed on day two of the inspection. A staff member that we spoke with at lunchtime was aware of the importance of providing the person with two small plates of food to encourage food intake.

Where people required thickened fluids, we observed that staff made drinks with people's prescribed thickener to the correct consistency recommended by SALT. People that had specialist dietary needs had a risk assessment in place and clear guidelines on what people could eat. On the second day of the inspection, inspectors tasted samples of the lunchtime menu. This included testing the consistency and flavour of both puree and mashed food given to people that had swallowing difficulties. What was on the menu was what was being served to people on the day of inspection. Mashed and pureed foods were presented well with each part of the meal being separate on the plate.

On the second day of the inspection we observed lunch on the dementia wing. People were served their meal in a timely manner. The food looked and smelled appetising. Where people required support to eat, staff were patient and communicative whilst supporting them. We observed positive interactions between staff and people.

Each care plan looked at had a record of all medical and health care professional visits that the person received or attended with details of the reason for the visit and the action taken. Visits were made by GP's, Speech and Language Therapists (SALT), Care Home Assessment Team (CHAT), district nurses and chiropodists. Admission and transfer forms were also available for each person so that continuity of care could be provided if a person was admitted to hospital. People told us that they were able to access

healthcare appointments when they needed to. One person told us, "Oh, I can get an appointment whenever I want. The staff will always help me." Staff were knowledgeable about people's healthcare needs and knew how to refer people for further healthcare assessment if necessary. A relative whose family member suffered from urinary tract infections (UTI) and could become easily confused if suffering from a UTI told us, "The staff notice when she is confused and figure it out straight away and get help."

We spoke with the visiting GP on the second day of the inspection. Feedback was positive and the GP said, "They [the home] are good at telling us if there is an issue. Staff send us a list of patients they may be worried about each week. It's quite a good team [at the home] and they know they can speak to us on any other days."

Is the service caring?

Our findings

We asked people if they felt that staff were kind and caring. People said, "Very much so, they try their best to always help you with anything they can," "They will try and take the time to help you with anything you ask them to" and "Yes, definitely." Relatives told us, "They [carers] are caring. They know all the residents names and the family members names" and "On the whole, yes [staff are caring]." During the inspection one relative said that staff did not wear name badges and that this may help people remember names if they did. We spoke to the registered manager about this who told us that this had been identified and the home was in the process of ordering name badges for all staff.

There was a good atmosphere in the home and people appeared relaxed. There was good interaction between staff and people and staff knew the people well. We heard positive conversations between care staff and people. For example, whilst a staff member was helping a person mobilise they were talking about the fruits they liked and which ones they ate. The staff member was also explaining that the person was due a visit from the GP that day. In the dementia wing we observed three people being transferred using the hoist. All staff explained to the people what they were doing and checked that the person was okay throughout the manoeuvre.

Staff were aware of asking for consent before carrying out any care tasks and we observed that staff knocked on people's doors before entering and asked discreetly if people needed the toilet and if they would like help. However, during lunch time we observed a moving and handling procedure where two carers were present. One staff member began to explain to the person what they were doing and asked them to sit forward so that they hoist could be placed into position. However, after that the carers did not communicate with the person to advise that they were going to lift them up or take them down. The second staff member had no interaction with the person at all. We fed this back to the registered manager at the time of the inspection.

Where people were unable to communicate with us, we observed interactions between staff and people. Staff spoke kindly to people, and appeared to know people well. During one interaction, we observed a staff member talking to a person about the music that they liked and going dancing. Another staff member was aware, and it was documented in the person care plan, that they responded well to large open hand gestures. We observed the person smiling when the staff member approached her in this manner.

Staff were able to explain how they treated people with dignity and respect. One staff member said, "You have to respect each individual that you are looking after, like giving personal care it needs to be in a private room and take care that the person is asked if it is okay to help them wash." Another staff member said, "Dignity is not just about personal care but making the individual feel involved and empowered." One person commented, "They [staff] do little things like talk to me in a respectful way."

People's waking and sleeping preferences were noted on their care plans. Most people that we spoke with told us that they were able to get up and go to bed when they wanted. However, two people said that they felt that staff put them to bed and woke them up when they were not ready to do so.

The home had a licenced bar in the dining room. The registered manager told us that whilst this was not used regularly, people were able to access it if they wanted a drink with an evening film or with their meal.

People's faith was noted in their care plans and whether they were practicing their faith or required support to attend a place of worship. The registered manager said that all of the people practicing a faith in the home were Christian and that a local priest came in to the home to conduct services. The registered manager said that if a person with a differing faith moved into the home their needs would be catered for and they would be supported to follow their faith.

Staff told us that relatives could visit whenever they wanted and relatives confirmed this. We observed relatives and friends visiting throughout the two days of inspection. Visitors were welcomed into the home and we observed staff greeting them and offering tea and coffee.

Is the service responsive?

Our findings

Care plans were person centred and contained detailed information about people including how they wished to be addressed, medical history and also covered information on their support needs such as communication needs, personal and skin care, mobility, eating and drinking, routines of daily living, social activities and hobbies, elimination, tissue viability, spiritual, cultural and sexual needs and night care. There was information within the care plans about specific things that mattered to that person. For example; 'I accept social contact and enjoy a hug from staff'. We observed the person approaching staff for a hug during our inspection.

Care plans also documented how each individual communicated and how staff could recognise their moods. For one person, their care plan noted, 'As I am unable to communicate my fears, I express myself by hitting my head or gripping myself by my clothes tightly.' There was guidance for staff, including a risk assessment, on how to work with this person on a one to one basis. Each care plan recognised that people reacted in different ways to situations and gave tailored information to ensure that people were appropriately supported. One relative said, "[My relative] is so communicative and staff picked up on that and engaged with her."

Care plans were updated annually or when people's needs changed. We saw that where one person's needs had changed the care plan had been updated to reflect this. Records showed that there were annual reviews of care with people and their relatives. Relatives that we spoke with confirmed that they were involved in planning their relatives care. One relative said, "Not long before Christmas it [the care plan] was reviewed. My brother and me signed it. She did have input into it and I helped her through it. It was quite extensive."

People's care plans had information on people that were important in their lives and how they stayed in contact with them.

Woodbury manor is a large building with extensive grounds, including an orchard. The home employed a grounds man to ensure that the grounds were well kempt and suitable for people to use. People living in the dementia wing had limited access to the grounds for safety purposes. However, the home provided a large, secure outdoor space for people living with dementia to access. Each person had a sensory garden box that they helped maintain in the summer months. Staff told us that people living with dementia would be escorted in the main grounds in more clement weather.

The home had two activities coordinators. Records showed and people told us that activities were discussed in the monthly residents meetings that were conducted by the activities coordinators. Activities were planned for the year and displayed on an activities timetable clearly documented on the hallway noticeboard. Activities included, external entertainers coming in such as singers, yoga and stretching, memory groups, crosswords and puzzles and dancing if people were able. The home had a second lounge that was used for film nights with snacks. The home had recently purchased a new mini bus to facilitate trips out. There were records of daily activities that each person in the home had participated in. This included one to one activities as well as group activities. People told us, "I get the paper which I enjoy reading and I

take part in the art club. I also like watching TV," "Yes plenty of activities are happening in here" and "Yes plenty of things [to do]." One relative said, "They have a few activities. Flower arranging, music, games, arts and crafts. They ask the residents what they want to do." We saw a calendar that had been printed for 2017 containing pictures drawn by people at the art club groups.

On the second day of inspection we observed an activities group. People were preparing window boxes and re-potting plants. This was supported by staff and the activities coordinator. We observed a lot of laughing and chatter between staff and people during the activity.

There was a hairdresser that attended the home on a regular basis. The home had a hairdressing salon with adapted sinks and chairs to ensure that people were comfortable. People were able to make appointments when they wished to. On the second day we observed two people having their hair done. The hairdresser knew people well and there was a good rapport. The hairdresser told us that staff encouraged people to make appointments and reminded them if people were not able to remember.

The home was dementia friendly. All bathroom and toilets had adapted taps that enabled people to use them easily. Taps had an automatic shut off to ensure safety. The dementia wing was decorated like a street and each person had a different colour door. This helped people identify their rooms. Bedroom doors had letter boxes and fake doorbells to make it look like people's own front doors. Outside each person's bedroom there was a memory box with photos and ornaments that meant something to them. Along the corridors there were window displays, made to look like old fashioned shops. This included sweet shops with tins of old fashioned sweets, a wedding display and old car and vans. The home was in the process of creating a small indoor area with a gazebo where people could sit if they wished.

People and relatives told us that when people moved into the home, they were able to bring items from home with them. This gave bedrooms a homely feel. We saw that people had brought things like armchairs, tables, pictures and ornaments to help them settle in.

At our last inspection we found that the home was not documenting or responding to complaints adequately. At this inspection we found that the home had addressed this issue. Records showed that complaints were documented. Complaints were divided into minor and major complaints. Each complaint detailed information about the complaint, action taken and the date it was resolved and had a written response to the complainant outlining any improvements made and apologies for the concerns that had been raised. Since February 2016, the home had received 2 major complaints and six minor complaints. Relatives and people that we spoke with were aware of how to make complaints. Information on making complaints and what people could expect if they did was provided to people when they moved into the home as part of the 'welcome pack.' People that we spoke with said that if they had a complaint they would go to the manager.

Is the service well-led?

Our findings

There was an open culture within the home. The registered manager told us that an open culture meant that staff were comfortable working in the home and understood the values that Scimitar Care promoted. The registered manager had been in post for 11 months and started a few weeks following the last inspection. Significant changes had been made in systems and processes within the home that have ensured that the home addressed the previous breaches and was now meeting the regulations. Staff were positive about the manager and told us, "She's good. A lovely person, really friendly and understanding. Always has time for the staff" and "She's [the registered manager] very supportive. There have been a lot of changes. I think for the better." Relatives said, "[Registered manager] is very approachable. We would approach her if we had a complaint" and "I like her she knows what she is doing and is easy to talk to."

We asked relatives if they felt that staff listened to them. One relative responded, "Yes, they do all the time. But the thing I like about this place [Woodbury Manor], when my mum had to be taken by an ambulance they had brought out all her paperwork. They know what is going on and respect our wishes."

We reviewed accident and incident logs. It showed that the manager used accidents and incidents as an opportunity for learning and to change practice or update people's care needs. Procedures relating to accidents and incidents were clear and available for all staff to read. Staff told us that they knew how to report and record accidents and incidents.

There were systems in place to ensure that staff training was up to date. Training records showed when staff needed to refresh training. Supervision records showed that staff were able to identify and request training.

There were regular audits of various aspects of the service. This included daily and weekly medicines audits, monthly audits of risk assessments and care plans. There were quarterly monitoring reports in the form of a mock CQC inspection, the last two in June and October 2016. This helped the registered manager identify areas that needed improvement. Staff files were audited by the compliance manager in October 2016. A six monthly health and safety audit had been completed in January and June 2016. Where issues had been identified from the auditing processes, these were documented. An action plan was created and signed off when the issues had been addressed.

Some relatives that we spoke with were not always aware that relatives meetings were taking place and said that they had not attended them but that they had attended social evening such as a cheese and wine evening. When we discussed this with the registered manager she told us that often these took the format of a social occasion with discussion. Relatives may not have been aware that these were a relatives meeting. Records showed that relatives and residents meetings took place in May and November 2016. Agenda items included catering and food, personal care, various aspects of daily living, decoration of the home, access to management and cleaning of the home.

Records showed and staff confirmed that there were regular meetings for heads of care, seniors and care staff. Meeting minutes showed that people's care was discussed, CQC requirements, policies and

procedures and changes to paperwork and legislation. For night staff there were meetings arranged at times that ensured that they were able to attend. Meeting minutes were available for all staff to read. During the inspection, we saw that a separate meeting had been booked for the housekeeping staff. The date and times of all staff meetings was clearly displayed in the staff room. Staff that we spoke with said that staff meetings were good and that it was, "helpful to hear everyone's point of view." Staff felt comfortable raising issues within meetings and also said that they felt able to approach the manager or heads of care if they needed to.

The home completed an annual survey with relatives and people that used the service. The most recent survey from the end of 2015 was available for people and relatives to read. This was provided following the inspection. Questionnaires were sent out and results collated into a short report. The survey was positive and noted any leaning for the home. The home was in the process of starting the 2016 survey.

All policies and procedures held by the service were up to date and included date for review. The provider updated policies as and when necessary according to legislation changes and reviewing care practices within the service.