Woodside Lodge Limited

Woodside 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 16 and 17 July 2018 and was unannounced.

The last inspection of Woodside Lodge took place on 5 and 6 January 2016 and rated the service as good.

Woodside Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Woodside Lodge is a converted property and accommodates up to 21 people who require care and support. When we inspected there were 19 people living in the home. There were two shared rooms in the property and single occupancy rooms of varying sizes. Rooms had ensuite toilet facilities and some had showers facilities.

There was a clearly defined recruitment procedure however we recommended that the provider research best practice in pre-employment checks.

Regular servicing and checks of systems and equipment were undertaken by the provider and the premises were clean. We recommended that a water safety and legionella risk assessment is undertaken by a competent person as per health and safety regulations and that staff attend legionella training relevant to their roles.

The provider committed to completing a full review of the premises and to undertake any outstanding maintenance tasks to ensure that health and safety and infection control standards are maintained until the service has been redeveloped.

Medicines were safely managed and staff asked people for consent before administering medicines.

Pre-admission assessments were completed and a wide range of risk assessments and care plans were regularly reviewed to ensure people's needs were effectively met.

Staff participated in regular supervisions and were supported by the registered manager who had an open-door approach providing less formal support.

Staff attended training in essential areas annually and accessed an online training system for both mandatory and other courses. The registered manager was qualified to support staff with moving and handling training.

Peoples nutritional needs were met. Menus were provided in different formats and meals were served as per people's requirements, for example pureed or fortified.

People told us staff were kind and caring and we saw staff interacting positively with people.

Spiritual needs were met and the service had links with the local church who regularly visited.

Care recording was electronic and the provider had sourced a system that could be updated to reflect the changing requirements of the service.

There were CCTV cameras in communal areas to monitor safety and footage was reviewed if there was an accident or incident. Footage had also been used as a learning tool for moving and handling.

The provider had installed several air conditioning units both in communal areas and in some bedrooms to ensure that people were comfortable during the warmer weather.

End of life care plans were created and when possible, people were supported to remain at the home if they wished supported by visiting healthcare professionals.

The registered manager and provider were visible and approachable, staff told us they would approach either if they had concerns about anything.

There were systems in place to monitor the quality of service delivery.

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.

Medicines were administered safely.

Sufficient staff were deployed to support the care needs of people living in the home.

Staff were trained in safeguarding and knew who to report concerns to.

Is the service effective?

Good

The service was effective.

People were assessed on admission to the home and regularly reassessed to ensure their care plans were person centred and current.

Staff were supported through formal and informal supervision meetings with the registered manager.

The provider was committed to maintaining a high standard of maintenance in the home.

Is the service caring?

Good

The service was caring.

People were supported in a person-centred way by staff who knew them well.

People were treated with kindness and respect.

Detailed life stories informed staff about people they cared for.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and involved people and their relatives.

Daily activities offered people stimulation and a chance to engage with others.

Technology including CCTV, sensor mats and an electronic care record system supported care delivery at the home.

Is the service well-led?

Good

The service was well-led.

Staff morale was good and the registered manager was approachable and open to new ideas.

There were systems in place to monitor and ensure a quality service was delivered.

There was a clear staffing structure and staff had a clear understanding of their role.

Woodside 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.

This inspection took place on 16 and 17 July 2018 and was unannounced. The inspection was undertaken by one inspector.

Before undertaking this inspection, we reviewed information we already held about the service. We requested and received feedback from health and social care professionals and looked at notifications submitted by the service to the Care Quality Commission (CQC). Notifications tell us about events that happen in the service that the registered manager is required to tell us about.

We reviewed the Provider Information Return (PIR). This is information supplied to us by the service annually which provides key information about what they do well and any forthcoming improvements. The PIR was completed more than a year before this inspection so we checked to ensure this information was still current.

During this inspection we spoke with eight people living in the home, three relatives, four staff members and the registered manager. We pathway tracked two people and looked at the records of three others. We checked recruitment files for four staff.

We looked at audits, risk assessments and service records for the location. We checked accident and incident reports to make sure they were reviewed and lessons learned.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Woodside Lodge. One relative told us "[Person] is safe, absolutely safe. I am at peace leaving [person] here when I go home".

The provider had recruitment procedures in place. Applicants completed a form, attended a formal interview where notes were taken, supplied references and were subject to a Disclosure and Barring Service check before commencing their position in the care home. The DBS check highlights potential issues around criminal convictions and shows if someone is barred from working with vulnerable people. This ensures that people employed at the service are suitable to work there.

We saw that two application forms had incomplete employment records. A full work history should be obtained from secondary education to the applicant's current job. Any gaps in the work history should be explained by the applicant. During our inspection we brought this to the attention of the registered manager who discussed employment histories with the staff members involved and arranged for full employment histories to be added to their personal files.

We recommend that the service research recruitment and pre-employment checks and update their procedures to reflect current best practice.

The provider completed regular checks and actions to ensure that the people were protected from the risk of legionella in the water supply. All hot and cold outlets were flushed and temperatures were monitored monthly. The service also took regular samples of water in the home and sent them for analysis. No legionella spores had been found in the water system. There was a brief legionella risk assessment in the homes overall environmental risk assessment.

In one of the bedrooms both hot and cold taps delivered water at similar temperatures, neither meeting the recommended safe level to reduce the risk of the growth of legionella spores. We checked training records and saw that the registered manager, nominated individual and the maintenance person had not attended a suitable level of legionella training. The lack of training and action to address the faulty outlets were of concern however the impact on people was minimal as there were no legionella spores detected in any of the samples taken for several years.

We recommend that the provider obtains a full water safety and legionella risk assessment completed by a competent person as set out in current health and safety guidance.

People were protected from potential abuse as staff had participated in training about safeguarding and received annual updates. Staff told us about different types of abuse, how they might recognise if someone were being abused and what action they would take should they suspect abuse was happening. The service held individual records of safeguarding incidents and an overall log of events. These matched notifications sent to CQC and it was evident that incidents had been thoroughly investigated and actions taken to prevent future similar concerns.

The provider retained a record of accidents and incidents that had occurred in the home. Causes had been investigated and if possible, actions were taken to reduce future incidents. Many of the accidents / incidents recorded were due to falls. Bed rails, crash mats and sensor mats were in place to minimise frequency and injury in those people most likely to fall. We saw on an analysis of incidents that in February 2018 there had been a much higher than usual number of falls. We asked the registered manager if this had been investigated and it had been due to one person sitting themselves on the floor rather than falling which had since stopped. The registered manager was aware that professional support for people could be sought through the GP or via a falls clinic.

The provider had considered potential risks in the home and taken actions to minimise them. Detailed risk assessments of the environment had been completed for areas including building, access, equipment, fire safety, trips, slips and falls, and accessing the grounds. There were also assessments to ensure the safety of staff working in the home and a specific assessment for staff members who were under eighteen years of age.

Regular safety checks were completed to ensure the safety of equipment in the home. For example, hoisting equipment, the passenger lift, catering equipment, fire safety and firefighting equipment and the call bell system. All were up to date and recommended actions where required had been taken.

We checked the premises for health and safety concerns and found that in one of the upstairs communal toilets there was no window restrictor fitted. Health and safety guidance recommends that where there is a risk of falling from height, robust window restrictors should limit the opening to up to 100mm. We talked with the maintenance staff member and they obtained and fitted a restrictor to the window we noted during our inspection and checked all other windows to ensure they complied with health and safety guidance.

We also saw that in one bathroom, flooring was no longer fully sealed at the edges of the room. In another toilet area the floor tiles and grout had cracked in places. One shower seat had hairline cracking. Both flooring and shower seat issues were concerns regarding infection control. Unsealed floors and splits in fixtures can harbour bacteria and cause infection. The provider and registered manager told us they would undertake a full audit of possible health and safety concerns such as the flooring and would commence a programme of fixing or replacing as needed. We have asked the provider to send us details of works completed.

We saw housekeeping staff cleaning throughout our inspection. There was a robust cleaning trolley which had lockable compartments for all cleaning products and an enclosed compartment for waste so it was contained and did not present an infection risk when the trolley was used. The housekeeper used appropriate personal protective equipment (PPE) such as apron and gloves and when using chemicals also wore goggles. A cleaning schedule check list was used and all areas were regularly cleaned. The home was mostly very clean and we noted no unpleasant odours. We saw that a vent in a communal toilet was heavily soiled with dust and there was a lot of cut hair in the bathroom used by the hairdresser. The registered manager planned for these areas to be cleaned. When a room became vacant, deep cleaning and decorating would take place before it was occupied again.

The service deployed sufficient staff to maintain the safety and provide care to people in the home. One person told us, "As soon as I ring the buzzer they are there". We saw staff able to support people with care without rushing and spending time speaking and enjoying time with them.

Medicines were safely managed. The service had a large lockable cabinet fixed to the wall in the manager's office, a locked medicines fridge and a second cabinet locked in a large cupboard to hold medicines that

would not fit in the main cabinet. Keys to the medicines cabinet were held by the registered manager or a senior care staff member depending on who had responsibility for medicines administration that day. Temperatures of the storage areas and medicines fridge were monitored daily to ensure that medicines were stored at the right temperature. The senior care staff member administering medicines wore a red tabard with 'do not disturb drug round in progress' to warn people and staff that they were unavailable while completing the medicines round.

We saw medicines care plans, protocols for giving PRN medicines and homely remedies. PRN medicines are prescribed to be taken as needed and not as a regular dose. Homely remedies are 'over the counter' medicines taken for the short-term management of conditions such as colds and allergies. PRN protocols reflected if there was a variable dose to be offered, people were asked if they needed one or two painkillers for example. Medicine administration sheets reflected how many tablets had been given. Homely remedies had been agreed and signed for as safe to offer by the GP.

Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. We looked at how controlled medicines were stored and accounted for. The cabinet was bolted to the wall and a count of stock matched the register. There was a weekly audit undertaken of controlled medicines. All other medicines were audited monthly.

Good

Is the service effective?

Our findings

On admission to Woodside Lodge, people's needs were thoroughly assessed. The care home used an electronic care record system that provided templates for assessments. The initial care plan assessment looked at areas such as dexterity, mobility, communication, sleeping and medicines among many more areas. These were completed for all residents and provided staff with a care plan to use while continual assessments adjusted and adapted the plan to develop and effective and person-centred care plan for the person.

Some people or their relatives were involved in the care planning process. Care was delivered as people wanted to receive it according to their plans. A life history for the person was recorded and details of likes and dislikes informed the staff team.

The provider used a range of recommended assessment tools to assess people's needs such as pressure sores, nutrition, falls, depression and pain. These were considered and if necessary care plans and risk assessments were developed to ensure people were cared for safely. Risk assessments and care plans were completed for all areas of people's lives and care in the home. Daily care and support needs, mental health and continence were among care plans we looked at, all were completed competently and provided a clear plan to ensure people received effective care and support.

Staff told us they received regular supervision with the registered manager. They told us they talked about training and were supported by the registered manager. One staff member told us they had supervision every six months however the registered manager told us they aimed to complete supervisions every three months. Each staff member had an annual appraisal, these were due to be completed in October 2018. The registered manager told us that at times it was not possible to release staff from their duties to complete supervisions. They had an open-door policy and staff were welcome to see the manager at any time if they needed support or advice and staff regularly took advantage of this.

We saw an overview of staff training showing if training was up to date or needed to be repeated. The registered manager told us that staff completed some mandatory training courses including infection control and moving and handling every year while other training was repeated every two years such as dementia care. One training course covered bathing and grooming. Staff told us they found this useful as supporting people with care can be daunting to new staff. The registered manager had attended a 'train the trainer' course and was able to provide in-house moving and handling training.

Staff told us they had been offered opportunities to complete care qualifications and develop their career. One staff member was training to be a senior care assistant and was completing a level three qualification.

Staff meetings were held with the registered manager and enabled effective information sharing and discussions about best practice and issues I the home. Specific meetings were held with night staff, kitchen staff and other staff as it was recognised that it would not be possible for all staff to attend a meeting. There was not a specific schedule for meetings, 'Next night staff meeting will be held in the next 3-6 months', was

included meeting minutes. There was no mention of the next meeting date in either the residents or kitchen staff meetings. Providing a regular schedule of meetings may enable more staff to attend.

People were supported to meet their nutritional needs. There was a varied menu available and if people did not like what was on offer for meals the chef would prepare something else. A nutrition care plan had been completed for people along with details of specific requirements such as meals being pureed, likes and dislikes and any allergies. One person told us, "They never offer foods I can't eat. They offer me a biscuit as I can't eat the fruit bowl". The chef had information about people's dietary needs and preferences available to him and there was a file containing the allergen information for each dish on the menu available to people and staff so they could check to see if foods were safe for them to eat.

The providerwas proactive in maintaining people's health and well-being and this included monitoring peoples weight. People were weighed at least monthly and if they were gaining or had become underweight action would be taken to as necessary. The chef described how they would add cream and butter to potatoes for someone who is underweight and would use lower fat options for someone trying to maintain or lose weight.

People had the right support to meet their dietary needs. The Speech and Language Therapy team (SALT) had provided plans for people who experienced difficulties with swallowing. People had different textures of diet such as soft or fork mashable and pureed. Fluid thickeners were prescribed and in use and some fluids were being given through a syringe as advised by the SALT team.

When people were reluctant to eat or drink, staff supported them. If a person did not eat with one staff member then they would wait a while and another staff member would offer support. If a person was reluctant to eat all day then night staff would support them. The registered manager said they had some success with this approach as sometimes people ate well at night and not as well in the day time. The provider took timely advice from GP's and dieticians when a person had no appetite for prolonged periods.

Staff members completed training in nutrition and food hygiene every two years in order to provide support for people as suggested by current best practice.

Staff were very patient and supportive to people with their meals. People needed varying degrees of support from being fully independent to needing to be spoon fed. People supported each other if they were able. We saw one person encouraging another to eat her meal, this happened frequently as they chose to sit together.

Information was shared between staff members at a handover meeting at the start of the day and night shifts. Night staff members would have an individual feedback session before the information was handed over to the day staff team as they had found giving feedback while staff waited difficult to manage. They meet with senior staff who take the information and share it with the team which works more effectively. Handover is completed using the tablets that support the electronic care records. Additional messages can be added to the electronic devices to be read at handover such as reminders to sign for topical medicines.

Staff members, though not nurses, were trained in some medical tasks. Staff could take blood pressures and perform other observations such as respiration and heart rates. We saw that staff and the registered manager had become concerned at a person's blood pressure being very low. They called the GP surgery and a GP attended within an hour to evaluate the person. The basic taking of observations was informative to the GP and supported them with their decision whether to visit.

One person had a pressure ulcer. A visiting healthcare professional gave positive feedback about the care provided to them. They told us 'They are a really good team and do what we ask them to do. We are realistic in our expectations, we wouldn't expect someone to be turned every 30 minutes, we would ask for a more realistic two hourly turn and they would do this as requested".

There were healthcare professionals at the home every day to support with medical tasks such as giving injections. The GP attended when needed and there was a visiting dentist and chiropodist. We received feedback from health care professionals about the home. "We are involved providing medical care of most of the residents at Woodside Lodge. Most of this is done at the request of the staff at Woodside, when they request a visit. They also make use of the local community care team for nursing needs. I would say that we do get fairly regular requests for visits from the staff but that the majority of these are appropriate requests and that the manager or staff are always helpful when we attend". The same healthcare professional also told us there was at times too much reliance on the community nursing teams however due to the home not providing nursing care this was acceptable.

There are plans to redevelop Woodside Lodge into a larger home on the same site. The timescale for this is approximately three years from when we inspected and will be a phased increase in size and move to a new building. As the new home will not be completed for some time the provider was keen to ensure the current premises was fit for purpose and met legal requirements. The provider had recently improved the premises fire safety following a commissioned report that recommended additional measures such as fire detection in roof voids and fire proof plaster boards. They committed to updating the water safety risk assessment and training and replacing flooring that was an infection control risk. They told us there would be ongoing maintenance and decoration until the new premises were commissioned.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

On admission to the home, people's capacity was assessed and then reviewed regularly. Staff were aware how to support people with decisions and were heard to ask for consent before providing people with support. The service also engaged a community mental health practitioner to support with best interest decisions as needed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that there were applications for DoLS authorisations for twelve people living in the home and one that needed to be submitted. Some had been authorised and some had not. The registered manager had resubmitted some applications as some time had passed since being sent. They were advised that the authorisations would be assessed at some point. The service was compliant in its practice around both the MCA and DoLS.

Good

Is the service caring?

Our findings

People told us they felt cared for by staff at Woodside Lodge. "[I feel] safe, cared for and happy, they are nice staff". A healthcare professional told us, "All the staff have a friendly helpful attitude and clearly care about the residents, probably the most important quality for delivering good care". Another health care professional said, "The staff are always looking out for the needs of their residents and are very proactive in their care. There is always a nice atmosphere when we attend and you can tell that the carers all care about the residents they look after".

People were treated with kindness and we saw staff chatting informally to them. We saw one person become happy and animated when the registered manager danced and sang with them. Another responded well when a staff member crouched down to their level and spoke quietly to them. We saw people and staff laughing and enjoying spending time together. People were addressed by their chosen names and staff appeared to know them well enough to engage in meaningful conversations with them.

A relative told us, "They go out of their way to know people and do what they would have done, staff would shave him and keep his clothing well cared for, he liked to be smart." Peoples care files contained life stories. Information was gathered about their occupation, where they were born, their parents, siblings, marriage and children. These were comprehensive and accessible to staff on the hand-held care plan devices. The electronic care plan system had a wide range of different risk assessments and care plans along with a day to day care record. We saw these had been personalised for each person and that there were no generic assessment or plans. The registered manager told us they had worked hard to ensure peoples records reflected their individuality.

The provider supported people to maintain their spiritual needs. A visiting minister attended with members of their congregation and held a service and a sing-a-long to music that people may remember. They told us, "They do a great job, it [the home] seems so familial, people are happy and engaged".

Staff treated people with respect. They knocked on doors before entering and would ensure curtains were pulled and doors closed before undertaking any care tasks. We saw staff ask people discreetly if they needed support with care and take them with minimal fuss. When administering medicines, we saw staff ask people if they wanted their medicines and talk to them throughout explaining what they were doing, this was particularly helpful when they administered eye drops to a person. If people appeared distressed we saw staff supporting them by speaking calmly and using distraction techniques to raise their mood.

People were supported to maintain their appearance and choose what to wear. People who were cared for in bed appeared to be wearing clean and fresh clothing, they had been bathed, their hair had been brushed and bedding was clean. In shared rooms there was a dividing curtain so that people could receive care in private.

Relatives told us they had visited at different times and were impressed that their family members appeared cared for whenever they had arrived. Relatives told us there were no restrictions on visiting times and that

staff welcomed them particularly when their family member was unwell or receiving end of life care. They also told us they felt supported by staff.

Good

Is the service responsive?

Our findings

A healthcare professional told us "In partnership when we have visited or planned care they do undertake any requests we make with regards to the acute collection or management of medication changes, following care plans and helping us by liaising with family members". Another healthcare professional said the home would follow advice and not 'freestyle' when it came to people's care.

Peoples care plans were person-centred and assessments were relevant to their needs. Relatives and people were involved in assessments and care planning. Areas assessed included mobility, nutrition, skin condition, communication and falls. If necessary a care plan was developed following the assessment. Care plans were not generic, each had been personalised. Care notes were completed regularly for people living in the home. In one person's care file there were thirteen entries describing care delivery or checks in one day. These ranged from night checks to details of what had been eaten, when and amounts of fluids taken.

The provider recognised that peoples communicated in different ways and presented information in different formats for them. The daily menu was displayed on a large blackboard written in chalk. For people that could not see or recognise the words there was a visual menu with photos of meals that were being served that day. Other people needed staff to tell them the menu verbally so they could choose their meal. If, when they chose their meal, they didn't like it then the chef would supply something else for them.

There was an activities noticeboard showing what was happening in July. Photos of entertainers, the hairdresser, church minister and dogs that visited with their regular times were displayed. The entertainer was pictured with the musical instruments they played as visual clues to who they were. Symbols and clip art were used to depict other activities such as an afternoon tea and a bingo session. A bright display of activity symbols were used to show an overview of the regular activity sessions.

We asked people if they enjoyed activities and they gave mixed responses. Some people told us they preferred to watch and another told us they wouldn't join in because they had a visual impairment. We looked at residents meeting minutes and nine people that spoke about activities gave positive feedback. It was evident from the activities we saw that some people enjoyed them. We saw a visit from dogs that people knew well and a bingo session which was the most popular activity offered. We were also told that the church service held monthly was very popular as people joined in with the singing. The minister told us, 'There is always a positive response from people". For people who were cared for in bed, staff would offer 1-1 activities including hand massages and reading books and poetry to people.

The provider used technology in the service to support people to stay safe. There were several alarmed pressure mats to alert staff if someone was getting up or had fallen. Doors had security codes to ensure people living in the home were safe and to prevent unauthorised access. A call bell system was available in each room, we saw that bells were within reach where appropriate. The electronic care system provided an easily accessible way for staff to make care notes and stay current with peoples changing needs.

Closed circuit television (CCTV) cameras were in use in communal areas and corridors. Appropriate consents

had been sought from people and staff for the overt surveillance and before installing the cameras people, staff and relatives had been consulted. The provider reviewed footage from the cameras if there had been an accident, incident, concerns about moving and handling or allegation, and cameras were only fitted in areas where personal care did not happen. Cameras were not installed in people's bedrooms or in any bathrooms to ensure that their right to privacy was not impacted upon.

Staff members used 'walkie-talkies' to communicate around the premises. Requests for care items, to support people and to attend different areas of the home were communicated using the radios meaning staff did not have to leave people unsupervised to communicated with colleagues.

We inspected during the hot weather and saw that the provider had installed air conditioning units. The main lounge that adjoined the dining room was a conservatory with a glazed roof which became very hot. Air conditioning kept this area, other communal areas and some bedrooms at a more comfortable temperature. If people became cold staff could reduce the air conditioning.

There were regular resident's meetings that relatives could also attend. The registered manager told us they tried to engage everyone in meetings and addressed each person individually to ensure they had a voice. We saw minutes from resident's meetings and topics covered included food, activities, care and carers. People could bring their own items to the meeting for discussion. The registered manager told us that there were often no relatives at the meetings however minutes were produced and they had an open-door policy and encouraged feedback.

The providers complaints procedure was displayed in the services reception. There had been no recorded complaints. There was a clear procedure and escalation if complaints were received.

People had end of life care plans in their care records. Consideration had been given to whether they would like to be resuscitated and if they had a signed 'Do not attempt resuscitation' (DNACPR) form this was shown on the main screen of the care record. The registered manager had also set up paper files for people to take with them if admitted to hospital with copies of the DNACPR, care plans and current medicines to avoid unwanted interventions. End of life plans contained practical information about the persons chosen funeral directors as well as where they wanted to die, who to inform and any religious or cultural considerations.

Good

Is the service well-led?

Our findings

There was a registered manager in post in the home who, though recently recruited into the role, had known the service for several years. The service was family owned and providing a family environment to people in the home was part of their ethos.

The service has a mission statement in the form of a pledge on their website. Providing 'Care and support appropriate to your needs, in a clean, comfortable, friendly, warm and supportive atmosphere,'. We saw staff members working to the pledge and received feedback from relatives that supported our observations. Relatives said the home was always clean when they visited and they felt welcomed.

Staff told us that the registered manager was supportive and approachable, if they had an idea to improve the service or had concerns they could approach them without fear of reprisals. The registered manager was supported by the nominated individual who visited the service daily. Links to dementia focussed organisations and local care provider groups enabled the registered manager to remain up to date with developments in care services.

The registered manager was supported by senior care staff who administered medicines and took a lead role in aspects of care delivery. The structure was clear and available to staff on the electronic care system with the providers policies and procedures. When we inspected the registered manager was visible, working on the floor, interacting with and providing care for people.

There were regular staff meetings and daily handover meetings. To reduce pressure on night staff at the end of a shift, the registered manager met with them then passed their information to the day team and added it to the electronic care record system.

The registered manager completed a range of regular checks and audits to ensure that service delivery was safe. Audits noted actions which were completed in a timely manner. When we inspected there were no outstanding actions. The registered manager was not currently undertaking night checks as they regularly worked night shifts and could check CCTV if they had any concerns. Accidents, incidents, pressure ulcers and infections were among areas audited.

The service was well known in its community. Links had been formed with the local church and charity events held in the home were open to the community. The nominated individual was an active member of a local dementia support group and a care providers association.

There were good links with healthcare providers, we received feedback from one who said, "I would consider Woodside, safe, extremely caring, effective, could perhaps do with more direction / experience with leadership and training for staff". The manager had been registered with CQC since March 2018 and had made progress in the role. They had set up routines for agency staff and inductions for new agency staff as well as developing team members and enabling them to progress into more senior roles in the service. Staff told us morale was good and this was apparent from the friendly and positive interactions we observed.

There was no specific improvement plan for the service in its current form. The provider was committed to maintaining the premises, ensuring safe service delivery and providing quality care to people. The improvement plan is focussed on the re-provision of the service in future years.