Woodbridge Lodge Limited

Woodbridge Lodge Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 December 2016 and was unannounced. Our last inspection of 10 and 11 May 2016 had identified shortfalls in a number of areas in the service. These included not involving people in their care planning, not obtaining appropriate consent from people, not effectively mitigating risk, not meeting people's nutritional needs and insufficient staff. At this inspection we found that improvements had been made in most areas but that care planning, the monitoring of people's fluid intake and governance needed to be improved.

The service provides care and support for up to 32 people and is located close to Woodbridge town centre. On the day of our inspection there were 20 people living in the service. Some people were living with dementia.

The service did not have a manager registered with the Care Quality Commission but the person managing the service had applied to register. 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 told us they felt safe living in the service. They however had mixed views as to whether there were sufficient staff. Staff told us that staffing levels had improved since our last inspection. Staff were allocated particular tasks throughout the day which could lead to a task based approach to care as opposed to a person centred approach.

Care plans were not always person centred. They contained generic statements which did not always relate to the individual. They also contained inaccuracies which could put people at risk of receiving inappropriate care and support.

People received support with their meals. The lunch time meal in the dining room was a pleasant experience with people supported to enjoy their meal. However, this experience was not replicated for those who chose to eat in their bedroom. Fluids were not appropriately monitored to ensure people did not become dehydrated.

People were supported to maintain their independence and do as much as possible for themselves. However, they were not supported with hobbies, interests and activities. People living with dementia were not always supported to lead meaningful lives.

Staff received training and support and were aware of their responsibilities with regard to reporting safeguarding incidents and the application of the Mental Capacity Act 2005. However, the reporting of safeguarding incidents was not always effective. We were also concerned that staff did not always demonstrate effective support for people living with dementia.

There were procedures in place to ensure people's medicines were managed safely. However, we found improvements were required in the monitoring of medicines prescribed to be taken as required.

The management team had made improvements since our last inspection in developing a more open and honest culture. Regular meetings were held with people and staff to encourage participation in the development of the service. However, there were continued shortfalls in the quality assurance processes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People had mixed views as to whether there were sufficient staff to provide safe care and support.

People felt safe living in the service. However, safeguarding referrals to the investigating authority did not always contain sufficient detail to enable them to be effectively assessed.

Medicines prescribed to be administered when required were not always administered appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received training in areas such as dementia and safeguarding. However, this training was not always effective in ensuring staff carried out the correct procedures.

People choosing to eat their meal in their bedroom did not always receive the required level of support.

Fluid intake was not monitored effectively.

The service was implementing the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

Staff demonstrated a caring approach to providing care and support.

People were supported and encouraged to be as independent as they were able.

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans did not reflect people's up to date care needs and personal preferences.

People were not supported to maintain their hobbies and interests.

The service had a complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The action plan following our previous inspection had not addressed all the issues identified.

Audits were not effective in identifying shortfalls and trends.

People, relatives and staff were kept informed and involved with the service through regular meetings.

Woodbridge Lodge Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 12 December 2016 and was unannounced. It was carried out by two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience of dementia care.

Before the inspection we reviewed information that had been sent to us by health care professionals and commissioners. During the inspection we spoke with eight people living in the service and two relatives. We case tracked two people with high needs. We also spoke with the operations manager, the providers quality manager, the service manager and three members of care staff.

We looked at five people's care records and records relating to the management of the service. These included policies and procedures, audits and quality assurance reports, training records and staff records.

We carried out observations of the care and support provided throughout the day. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Our inspection of 10 and 11 May 2016 had found that staffing levels were not sufficient to provide people with the care and support they required which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following that inspection we met with the provider and an action plan was received.

At this inspection manager told us that staffing levels were calculated using the Barthel dependency tool. This is a tool which calculates the number of staff required based on people's dependency levels. They told us that staffing levels were currently in excess of those indicated by the tool. They also told us that they had recruited a number of new staff and there was little use of agency staff. The service had been using this tool at our previous inspection but had not been applied it effectively. Since our previous inspection the service had re-assessed people's needs as part of the application of the tool which had resulted in improved staffing levels.

At this inspection people did not feel there were sufficient staff. One person said, "This wheelchair can be uncomfortable but they are very good, they transfer me to a comfy chair in the afternoon. Sometimes there is enough staff; sometimes we could do with more. It affects me in that you have to wait a bit longer." Another person said, "The staff are friendly, but when they are very busy they sometimes don't want to know, but they only have one pair of hands. A relative said, "I do think they could do with more staff." However, people told us they did not have to wait long if they needed help from staff and used their call bell. One person said, "I've not really had to wait long, but they can't be everywhere at the same time." Another person said, "You have a buzzer to call someone and there's always staff around."

Staff told us that staffing levels had increased since our last inspection. A senior member of staff told us, "[Staff] get allocated a job every day." They explained that this worked well as, "[Staff] know what they are responsible for." Records showed that staff were assigned specific roles each day such as responsibility for food and fluid charts, care and comfort records and baths. This was a very task focussed method of providing care and support and did not encourage staff to see people as individuals but to concentrate on allocated tasks.

Staff records demonstrated that appropriate checks had been carried out before people were employed. Pre-employment checks included Disclosure and Barring Service (DBS) checks and obtaining two references. The DBS restrict people from working with vulnerable groups where they may present a risk and also provide employers with criminal history information. This meant that the manager ensured the risks of employing unsuitable people were reduced.

Our previous inspection had found that risks to individuals were not managed to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the management of risks to people from receiving care and support had improved. For example the risk of people falling had been assessed and action plans to prevent falls were in place. These were specific to the individual, one risk assessment recorded, 'Offer PRN (medicines to be

administered as required) if showing signs of a limp as pain may inhibit my movement.' The risk of people developing pressure ulcers had been assessed and action plans put place to mitigate any identified risk. Where actions were required to mitigate the risk these were being carried out. For example one person's risk assessment recorded they required to be repositioned every three hours and we saw that this had taken place.

People told us they felt safe living in the service. One person said, "I feel safe, I have got a nice room, a wireless and a bed." A relative told us, "I do feel [relative] is safe, now when I come in [person] is clean, tidy and well fed." However, we found that possible safeguarding incidents were not always fully investigated which meant that we could not be sure that the correct action had been taken. For example, the manager had contacted the multi-agency safeguarding hub (MASH) regarding the behaviour of one person towards another. However, our analysis of the behaviour showed that the details of incident had not been fully communicated to the manager by care staff. The manager was therefore not able to pass on the fully gravity of the incident to the MASH. This may have meant that the MASH team would have taken a different approach to the incident had they been given the full picture. We fed back our concerns to the manager.

Staff we spoke with told us they were aware of the service safeguarding procedures and how to escalate anything which caused them concern. One member of staff said, "I'd write a complaint and give it to [manager] if they weren't here I'd go to [operations manager]. There are posters in the office. You can call the MASH [Multi Agency Safeguarding Hub] team and there is obviously CQC." However, the example in the previous paragraph demonstrates that staff may not fully understand safeguarding issues.

People were protected by safe systems for the storage, administration and recording of medicines. Medicines were kept securely on each unit. Medicines administration record (MAR) were received printed from the chemist. These were checked before being put into the MAR folder. This gave a clear audit trail and record of people's medicines. Regular audits of medicines and MAR were carried out and action taken to address any problems identified such as medicines which had not been signed for. However, we found some miscommunication regarding one person's medicines which had been prescribed to be taken as required (PRN) and insufficient detail as to when the person should be given their PRN medicine. The member of staff we were observing administering medicines told us that one person received their medicine, which was prescribed as PRN, every morning. We checked with the manager if this was the case and they told us that the person should only be receiving this medicine if they required it. Although there was some confusion as to whether the mental health team had given different advice. The manager told us they would contact the person's GP for a review of this medicine. In addition the protocols explaining when this person should receive their PRN medicine were brief. They did not fully describe the behaviour the person may display when they required their medicine or any actions which should be taken to address the behaviour before administering the medicine. This could mean that the person was receiving their medicines inappropriately. Staff had received training to administer people's medicines.

Our previous inspection had also raised concerns regarding infection control procedures. At this inspection we found that infection control had improved. We observed staff using appropriate infection control procedures, for example using person protective equipment when providing care and support. There were paper towels and soap available in the kitchen and bathrooms. The manager carried out regular infection control audits.

Requires Improvement

Is the service effective?

Our findings

Our inspection of 10 and 11 May 2016 had found that people were not supported to maintain a healthy diet and that where people needed their food and fluid intake monitored this was not always carried out. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that some improvements had been made in particular to the dining experience in the service dining room but that fluid monitoring was not being carried out effectively.

Fluid balance charts were in place for eight people. However the recorded target amount for each person varied daily. For example the target for one person varied between 1500 and 1002ml a day. The manager had introduced a new way of calculating fluid targets based on people's weight but since this had been introduced, three days before this inspection, targets had not been completed at all. A member of staff said, "Until recently we used to do everyone at 1500ml now it is done by weight. It's a new thing, everyone should be doing it." Another member of staff told us "I always try to make sure the [fluid] charts are done." However, when we asked them about calculating fluid targets they commented, "I don't understand that." Without clear information to show what people's fluid intake should be staff could not be certain whether people were achieving their target intake or whether they may be at risk of dehydration.

For some people, the amount of fluid they had actually consumed was at times less than a quarter of their target. Care plans included a section which held details about people's nutrition and hydration however this included very little information about how fluids should be encouraged if their intake was low. For one person who consistently fell far short of their recommended daily fluid intake their care plan read, 'dehydration.' There was no information to explain the effects this could have on the person. There were also no details of strategies staff could try to promote an increase in the amount of fluid this person consumed throughout the day. Another person's care plan stated, '[Person's] fluids can be poor and requires verbal prompts from staff to encourage [person] to drink.' The manager had signed people's fluid charts and written comments such as, 'Try pushing fluids harder.' However, there was no indication how staff should do this or information about what may work best for people, such as their preferred drinks, cups or the times of day they may like to have a drink.

The meal time experience in the service dining room was positive. A member of staff told us, "Lunchtime used to be a bit all over the place. We used to all queue up. Now we join the residents, they like talking to us." People were given the choice about where they would like to sit in the dining room. A member of staff assisting a person sitting in a wheelchair asked, "Would you like to sit next to [person]?" A member of staff sat with people at each table and chatted with them to help them make a decision about what they would like to eat. Menus were provided on each table and we heard a member of staff ask a person, "Do you want me to read it for you?" People were offered a choice of drinks and assisted appropriately throughout their meal. Equipment such as plate guards were provided to assist people to eat independently where appropriate. The maintenance person employed by the service also ate their meal sitting with one person and staff later explained how the person enjoyed their company so this was something they did most days. When staff saw that people were not eating their meal they were offered alternatives. For example, one person was asked by a member of staff, "Would you like some ice-cream instead? Or yogurt or fruit?" One

person asked for some apple pie. The member of staff explained to them, "You've already had some apple pie. Would you like some more?" This was quickly provided for the person when they said that they would like another piece. People were served with hot drinks after they had eaten and were all given the opportunity to say what they would like without any assumptions being made by the staff.

However, dining experience for people who chose to eat their meal in their bedroom was not as enjoyable. We observed one person was struggling to eat their meal. The person, who had reduced vision, was struggling to get anything on their fork. They commented, "I don't know what to choose as I cannot see what's on the end of my fork." The person put some food in their mouth and then spat it out as they did not like it. This person's care plan recorded that they should be served their food already cut up but the meal we observed them eating had not been cut into bite size pieces. We asked the manager how this person was supported to eat. They told us that the person was very independent and was embarrassed to eat in the dining room. This person's care plan did not record what support they had been offered to enjoy a communal meal, such as a carer putting their food onto their utensils, or to eat themselves, such as a plate guard. Another person was served their main course in their room at 12.45 pm. This person was not offered a desert. When their plate was collected at 1.50 pm they said they would have liked a desert but decided not to due to the time they had had to wait. The lack of support with eating and delay in providing food to people who ate in their room could mean that they did not receive adequate nutrition.

Drinks and snacks were readily available on tables throughout the communal areas of the service. A person said to us, "There are always crisps, chocolate and fruit available." It had been established for one person that they found it difficult to sit and eat a full meal but were happy to graze on snacks throughout the day. We saw this person walking around eating a bag of crisps and later saw that this had been recorded on their food intake chart. The availability of snacks in this way meant that people could take their nutrition in a way which suited them.

Our previous inspection found that staff had not received appropriate training and supervision which was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made. The manager had put a system in place to ensure regular supervision of staff was taking place. Staff confirmed that they had carried out an induction when they first began working in the service. One member of care staff said, "There was a big induction list I had to do and check off." Another member of staff said, "We've done fire, dementia, DoLS (Deprivation of Liberty Safeguards). Dementia is one of the longest, two to three hours, everyone does that one." Another member of staff said, "To a lot of the staff dementia is a new thing." We asked them whether staff received training in how to deal with challenging behaviours. They said, "Maybe we don't but it is part of the dementia course." Staff did not always demonstrate an effective knowledge of how to support and distract a person who may be becoming agitated or distressed. We observed one incident where a person living with dementia wanted to make a telephone call and had taken the telephone from a member of staff. The member of staff was unable to distract them away from the telephone. We are concerned that with the number of people living with dementia in the service staff do not have sufficient training in dementia and managing challenging behaviour. This had resulted in the poor reporting of challenging behaviour to the manager and the high number of incidents.

Our previous inspection found that the service was not appropriately implementing the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguarding (DoLS). This was a breach of breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made.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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked at this inspection whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had made appropriate applications under the DoLS to be authorised by the relevant authority. These were appropriately recorded and monitored. Care plans also recorded where relatives had legal powers to make decision for people. This ensured the service was aware of what decisions could be made on a person's behalf.

We observed staff speaking with people and gaining their consent before providing support or assistance throughout the day of our inspection. For example where they wanted to sit and whether they wanted a drink.

Our previous inspection found that improvements were needed to the design and decoration of the service to meet the needs of people living with dementia. At this inspection we found that some improvements had been made. The service was undergoing a planned redecoration and the environment was clean and fresh. Furniture was arranged to promote conversation for example in the lounge the chairs were arranged in two semi circles.

People had their day to day health needs met. One relative said, "Staff have been extremely good, especially recently as we have had a lot of sickness, making sure they are ok." Care plans recorded when people had been visited by a health care professional such as a chiropodist or dietician.

Good

Is the service caring?

Our findings

Our inspection of 10 and 11 May 2016 had found that the service required improvement as staff did not always know the people they were supporting and treat them with dignity and respect. Th provider had addressed this in their action plan following the inspection. At this inspection we found that improvements had been made. A relative told us, "Staff are very good, kind and helpful."

We observed staff showing concern for people's wellbeing throughout the day and responding to any requests promptly. For example, staff brought a person to sit in the conservatory in their wheelchair. The person expressed concern that it was cold, the member of staff immediately offered to take the person to a different room or get them a cardigan.

Staff spoken with demonstrated a caring approach to the provision of care and support. One said, "The improvements since I've been here have been substantial. Staff are more caring, affectionate, friendly to residents. When I first came they were talking around [people] not to them. Like when doing personal care. It has absolutely changed." Another said, "The residents. I love them to bits. They've become like a second family."

Staff understood and put into practice effective ways of supporting people to exercise choice, independence and control, wherever possible. A member of staff told us, "We've got [person] who is happy to do [their] own personal care but they'll buzz when they need help to stand. We don't want to take their independence away." Another said, "We try to prompt people to stand before we use equipment." We observed interactions between people and staff which confirmed this approach.

People told us that their privacy and dignity was respected. Referring to how they received their personal care one person said, "I can do my private parts myself and dry myself as far as I can. They [staff] are very good with dignity." People were free to access communal areas of the service or stay in their bedroom if they preferred. One person told us how they liked to stay in their bedroom and read the newspaper. Relatives and friends were able to visit when they wished and we saw visitors coming and going throughout our inspection. We observed a member of care staff asking a person if they would like to use the toilet in a discreet manner so as to protect their dignity. Staff were able to give examples of how they respected people's privacy and dignity whilst providing person care.

People's records were kept securely on a computer system which was password protected. What information a member of staff could access on the system was dependant on the seniority of the staff member. Meaning that only more senior staff could access more sensitive information.

Requires Improvement

Is the service responsive?

Our findings

Our inspection of 23 June 2015 and 10 and 11 May 2016 found that the service did not involve people in their care planning and that care plans were contradictory and did not always reflect people's needs. This was a breach of breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made in people's involvement in their care planning but that care records required further improvement and there was a continued breach of Regulation 9.

People were not able to tell us if they recalled being involved in their care planning and due to the fact the system was computerised there were no signatures to demonstrate they had been discussed with the person or their relative. However, minutes of relatives and residents meetings demonstrated that people had been encouraged to contribute to their relatives care planning.

Care plans were not written in a person centred manner, were not always accurate and did not reflect people's changing needs. They contained numerous generic statements which did not always fit the person. For example, three care plans we looked at contained the statement 'When bathing I use a hoist and a non-slip mat to assist myself.' There were no details of what support the person required when bathing or what type of hoist they required and the size of any associated sling. This may mean that the person was not appropriately supported with bathing or maybe provided with inappropriate support. Another care plan recorded on the first page that a person had no allergies to medicines but further into the care plan recorded a medicine they were allergic to. This put the person at risk of receiving a medicine they were allergic to. Another care plan recorded that a person required 'some assistance' with their personal care. There were no details of what the person could do for themselves, what they needed help with and what their personal preferences were. The lack of staff knowledge about people was reflected in a comment by a person who said, "The staff is the main thing that's good about here, they are all very obliging, willing to help. They should be told about us first but sometimes they just don't seem to know. The girls are very patient with us infirm ones." A senior member of care staff told us that "[Care plans] should be accessed by all staff. They can all look at them. They should do. They then went on to say that staff found out about people, "More through interaction. If we know something that works with someone we will pass it on." More detailed and personalised information in care plans would enable staff to become familiar with people's care and support preferences and needs before needing to be told by the person.

The service supported people living with dementia. Care plans for these people were more detailed but were still not specific to the individual. For example, three care plans contained the same statement, "Where it appears to help, reminding me of where I am in a conversation will help me maintain my sense of self and enhance my confidence." It appeared that these statements had been picked from a pre-populated list. Senior staff confirmed that this was the case but that they could be changed if required.

A further generic statement in care plans related to mirrors in people's bedrooms and their reaction to their reflection. Seeing their own reflection in a mirror can cause some people living with dementia distress. Two care plans stated, "If [person's] reflection causes distress, consider removing mirror from the room." This

was not specific to the individual or clear whether or not the person should have a mirror and did not identify any action that had been taken. We checked the bedrooms of these two people and found they both had large mirrors in their bedrooms. There was no indication in their care plan as to whether they had ever found a mirror distressing.

People living with dementia may have times when they demonstrate behaviour which may cause them or others distress/anxiety. The effective recording and monitoring of these incidents enables effective support to be accessed. A member of staff told us about the way one person had been effected . They commented, "It's quite a recent thing. [Person] has deteriorated quickly, I'm not sure that staff expected it. I'm not sure that person's care plan has been updated." We checked and found that the person's care plan had not been updated. We also found that 16 people had at least one incident of this kind(some had 15). Most had no care plans in place for it and the manager was not aware of the number of incidents prior to us analysing the information. Care plans did not provide staff with information on what may trigger an instance of challenging behaviour and any methods to address the behaviour. Staff had not reported them other than recording on the computer system. There was no system in place to monitor incidents of challenging behaviour to check whether the number of incidents for a particular person were increasing in number of intensity. After the inspection we asked the manager and the quality manager to provide us with further information regarding their monitoring and actions. They have advised that a number of incidents have been recorded incorrectly. However, they also advised that six people had a high number of incidents, one person having 29 . Therefore we are not assured that systems have been put in place to protect and support the people where this is a risk to their or others wellbeing. This also includes supporting staff in these situations.

People were not always supported to follow interests and take part in social activities which interested them. One person said, "I get very bored, listen to the radio, I can't see the TV, I can't read. This afternoon I have a friend coming. I stand at that chair and do 100 steps." Another person said, "I'm never bored because I'm either asleep, I have the telly if there is anything on. I miss gardening more than anything and cooking. I used to love cooking." This person's care plan did not contain any record that they had been supported to access the service large garden or to participate in cookery, either as specific activity or with the service cook.

We observed one person who was living with dementia but was physically fit and very mobile. Their care plan said they liked listening to music, doing jigsaws, playing ball games or playing bingo with help. It also stated, 'I need someone to encourage me to join in with activities and to give support'. The care plan stated that the outcome was 'To provide stimulation'. We observed this person throughout the day and saw that they were not provided with any of the activities listed above or encouraged to engage in any other activities.

Staff told us they provided activities for people. One member of staff said, "If the activities co-ordinator is sick or not in we will go and do games. Especially at the weekends when it's quiet. It keeps people entertained." Another member of staff said, "I'd like there to be more. A lot more has gone on but activities need to be encouraged. [People] are a lot calmer when doing activities." The reference to people being calmer was perceptive as people who may exhibit challenging behaviour are less likely to display the behaviour if they are engaged in an activity which is meaningful to them.

This was a breach of Regulation 9 – Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt able to approach the manager if they had any concerns. One person said, "[Manager]

is always free. If you have a problem [manager] is always there." The service had a formal complaints procedure which was displayed in the service and available to people in their bedrooms. The manager told us that they had not received any formal complaints since our inspection of May 2016.

Requires Improvement

Is the service well-led?

Our findings

Our inspection of 10 and 11 May 2016 found that the service was not well-led. This was because the service did not have an open and transparent culture which encouraged open communication and monitoring and auditing within the service was not effective. This was a breach of breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the earlier inspection the provider had recruited a new registered manager and provided enhanced support for the new manager. At this inspection we found improvements in the culture of the service but the monitoring and auditing process required further improvement and still demonstrated a breach of Regulation 17.

Following our previous inspection the service had put in place an action plan showing how they planned to improve the identified areas of concern. The action plan had been effective in improving the quality of the some but not all, of the areas identified in our previous report. For example staff were now up to date with training and were being regularly supervised. However, care documentation did not always reflect people's care needs and was not always accurate. This put people at risk of receiving inappropriate care and support.

There were regular audits in place for areas such as staff training and the quality people's meal time experience which had improved those areas of the service. However, not all audits were effective. For example the audits of the care plans had not identified the number of incidents of challenging behaviour in the service and the lack of fluid monitoring mentioned previously in this report. Ineffective audits and an action plan which had not dealt with the issues identified in our previous report did not demonstrate good management and leadership of the service.

The service did not have a registered manager in place. However, the manager recruited by the provider since our last inspection was applying to register with the Care Quality Commission. People and staff were complimentary about the new manager and praised their abilities. A relative said, "[Manager] is great, [manager] has worked really hard, it's so much happier. The whole place is now working so nicely, they listen to what we said." A member of staff said, "Recently it's so much better. It helps with [manager] being the manager. We've been through so many managers. [Manager] is the best one we've had. [They] do things for us. If we are needing help [manager] is very happy to do hands on stuff." The provider had also recruited a quality manager who was working with the manager to improve the service. Both the new manager and the quality manager had attended meetings with people and families to introduce themselves and their role.

There were regular meetings with people, families and staff to encourage people to become involved with the service, encourage feedback and drive improvement. Minutes of a recent relatives meeting showed that the provider had given details of recruitment they were undertaking and provided feedback on planned improvements to the service. Minutes of a recent staff meeting had provided feedback to staff on how the dining experience for people was improving and how to support people with their night time routine.

We discussed the service computerised care planning system with the manager and quality manager in light of the shortfalls we had identified in personalisation of care plans and the monitoring of incidents of

challenging behaviour. They told us that the provider had recognised that the system needed improvement and was trialling an improved system in other services and if this was successful it was planned to roll this out to Woodbridge Lodge.