Care Quality Commission

Scimitar Care Hotels plc

Woodbury Manor

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

Overall summary

This inspection took place over two days on 26 and 27 November 2015 and was unannounced. At our last inspection we found that the provider met all standards that we inspected.

Woodbury Manor is a 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 slight degree of dementia.

The home's registered manager had left the week that we inspected. 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. The operations manager and a head of care for Woodbury Manor were present throughout the inspection.

Summary of findings

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 were able to explain the principles of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). However, only one person had an MCA assessment in place. The provider had failed to ensure that people they had identified as potentially lacking capacity were appropriately assessed. There were 38 people who had been identified as requiring a DoLS but these had not been applied for.

There were weekly fire alarm checks. However, the provider had not put personal evacuation plans (PEEPS) for people who required specific help in case of a fire. This put people at risk.

There were person centred care plans that allowed staff to provide appropriate support to people. Care plans stated people's likes and dislikes and contained detailed life histories.

Staff did not receive regular supervisions. Supervisions that we saw were brief and did not support staff to carry out their role effectively. There were no appraisals for staff for the past two years.

The provider did not record complaints effectively. There was no evidence that management used learning from complaints to drive quality of care.

People were supported to maintain a healthy lifestyle and had healthcare appointments that met their needs. These were recorded and monitored on a regular basis. Medicines were administered safely and on time. Staff had completed training in medicines and administration.

People told us that they felt safe within the home and well supported by staff. Where people were unable to talk to us, we carried out a 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.

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.

The provider completed annual surveys with people and relatives. Action plans were created following surveys to help maintain and improve quality of care.

The home had two activities coordinators and there was a full programme of activities both internally and externally to the home. People were consulted during regular residents meetings about what they wanted to do. People felt that their views were listened to and acted upon.

The home was clean and well decorated. The provider had ensured that décor and layout of the home supported and assisted people living with dementia.

We found that the service breached four regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014. Where there were breaches of regulations, you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 

Some aspects of the service were not safe. People had not been assessed for personal evacuation plans (PEEPS) in case of fire. This put people at risk of harm.

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

People who used the service had comprehensive risk assessments to ensure known risks were minimised.

There were sufficient staff to ensure people's needs were met.

People were supported to have their medicines safely.

Is the service effective?

Requires improvement 

Some aspects of the service were not effective. Although staff understood the MCA and DoLS, Mental Capacity Act (MCA) assessments had not been completed for people. Deprivation of Liberty Safeguards (DoLS) had not been applied for.

Staff supervisions were not regular and there were no appraisals for staff recorded.

Peoples healthcare needs were monitored and referrals made when necessary to ensure wellbeing.

People were supported to have enough to eat and drink so that their dietary needs were met

Is the service caring?

Good 

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

People were treated with respect and staff maintained privacy and dignity.

People were supported to make informed decisions about the care they received. Staff gave people explanations in a way that they could understand.

Staff were patient and kind in their interactions with people.

Is the service responsive?

Requires improvement 

The service was responsive. People's care was person centred and planned in response to their needs.

Staff were knowledgeable about individual support needs, their interests and preferences.

People were encouraged to have full and active lives. There were regular activities within and externally to the home.

Summary of findings

Is the service well-led?

Some aspects of the service were not always well led. Complaints were not well documented or acted on effectively.

There was an open culture within the home.

Some audits had been completed. However, overall management failed to ensure appropriate documentation was maintained.

Requires improvement

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 26 and 27 November and was unannounced.

Before the inspection we reviewed notifications and other information that the home had sent to us.

This inspection was carried out by two inspectors, a pharmacist 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.

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 12 people who use the service, 13 relatives and ten staff. During the inspection, we spoke with two health care professionals who work with the home; an occupational therapist (OT) and a district nurse.

We looked at eight people's care files and 10 staff files as well as other paperwork held by the home.

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe. One person said, “It’s nice here. I love the nurses and feel very safe.” Another person said, “I feel safe. I never even think about it.” Relatives told us, “My [relative] is safe here and seems very happy”, “Yes, my [relative] is safe. If I didn’t think she was, I wouldn’t let her stay.”

The home had up to date maintenance checks for gas, electricity, electrical installation and fire equipment. Fire alarms were tested and recorded weekly. However, there was no evidence of recent fire drills. There were no personal evacuation plans (PEEPS) for individuals, in case of a fire. A PEEPS assesses how people should be evacuated if they have mobility issues and the best way for staff to support them. The homes fire safety policy stated, ‘Individual PEEPS should be offered to residents upon arrival where they feel they need special assistance during evacuation. A specific risk assessment will be performed by the manager’. This had not been completed for any people living at the home.

This was in breach of Regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were records for 'as needed' (PRN) medicines. However, there was no guidance for staff on when these should be administered to people. The head of care said that this would be addressed so that staff were aware of when as needed medicines should be given. The home had a separate cabinet for homely remedies and guidance on administration was available for staff. Homely remedies are things like, constipation relief and cough and cold remedies. The medicines policy was available for staff to read. There were also up to date records of medication disposal and staff were able to tell us about the correct procedure.

People’s current medicines were recorded on Medicines Administration Records (MAR) and used the bio-dose system provided by the local pharmacy. The bio-dose system provides people's medication in a pre-packed plastic pod for each time medicine is required. It is usually provided as a one month supply. Staff had received training on medication administration. We looked at nine people’s MAR sheets. People's medicines were given on time and there were no omissions in recording of administration. We saw that one person’s medicines had been changed by the GP. The MAR sheet had been updated to reflect these changes. The GP reviewed people’s medicines on a weekly basis. However, there was no evidence of medicines audits.

Staff had ‘protected time’ for administration of medicines. They were able to complete medicine administration without being interrupted to complete other tasks. We observed medicines being administered to people. Staff used appropriate hygiene procedures, such as hand washing, prior to administration and took into account individual needs and preferences. For example, one person required extra time and encouragement to take their medicines. We observed staff help the person up to a vertical position before giving them their medicine. This protected the person against the risk of choking. We spoke to people who said they were happy with their medicines arrangements with the provider, received them on time and felt supported with their individual preferences and needs.

The home had two hoists for moving and handling. There were up to date records of hoist maintenance. However, people did not have individual slings based on their weight and needs. The provider told us that people shared slings but that they were washed regularly. This may increase the risk of cross infection and the provider said that they would look into individual slings for people who needed them.

There were sufficient staff to allow person centred care. We saw that there were two heads of care, three senior carers and nine cares throughout the day and 1 senior carer and 5 carers at night. The provider completed a needs assessment for all people when they moved in. A needs assessment identifies what level of support people require. The operations manager told us that if people’s needs increased they would assess staffing levels. However, there were no systems in place to show how the provider monitored this and needs assessments were not reviewed.

Staff were able to explain how they would keep people safe and understood how to report it if they felt people were at risk of harm. One staff member said, “Safeguarding is to protect residents from any harm such as abuse and to report it if you see it.” Staff were aware of the homes safeguarding policy which was accessible to all staff. Training records showed that staff had completed training in safeguarding, the Mental Capacity Act (MCA 2005) and Deprivation of Liberty Safeguards (DoLS). Staff understood what whistleblowing was and how to report concerns if necessary.

Requires improvement

Is the service safe?

Risk assessments were tailored to the individual and gave staff guidance on how to mitigate specific risks in the least restrictive way. All care files that we looked at contained assessments for falls. The assessments graded falls as low risk, medium risk and high risk. Where the assessment was scored as medium or high, we saw that risk assessments were in place for people setting out clear actions for staff to mitigate the risk, this included the use of bed rails and pressure sensors next to people's beds. One person's risk assessment noted that they were at risk of developing urinary tract infections (UTI's). There was clear guidance for staff to ensure that the person's fluid intake was regular and recorded. We saw fluid charts which showed that this was regularly recorded. Staff were able to tell us what individuals needs were in relation to their risk assessments.

People were checked hourly at night. We saw records of hourly checks and any actions undertaken by staff such as, assisting people to go to bathroom or changing pads were recorded. Care plans noted what specific care an individual would need during the night and staff were assigned to ensure that this was carried out. We also saw that where people said that they did not wish to be checked at night, they had signed a form stating their wishes. This had also been signed by family members, with people's consent.

All people had pressure mattresses as standard to prevent pressure ulcers developing. 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. However, we saw that all people had been assessed but the assessments were not dated and there was no evidence of how often the Waterlow score was reviewed.

There were records of accidents and incidents. The head of care told us that any staff could report accidents and incidents and staff were aware of how to do this. Staff that we spoke with were able to tell us the procedure for reporting. Accidents and incidents are monitored monthly by the head of care. We saw that where necessary, accidents and incidents were used to improve care. One person's risk assessment had been updated following an accident and safeguards put in place to mitigate the risk.

If a person had two falls or more within a month period, they were referred to the falls clinic. We saw that risk assessments were updated following the falls clinics and people regularly monitored.

The service followed safe recruitment practices. We looked at ten staff files which showed pre-employment checks such as two satisfactory references from their previous employer, photographic identification, their application form, a recent criminal records check and eligibility to work in the UK.

There were records of maintenance checks. Staff were aware of how to report any maintenance issues. The home employs a 'handy man' that addresses any maintenance issues. We saw that things were dealt with in a timely manner and signed off by the registered manager.

The home had emergency contingency plans in place in case of fire, flood or anything that would make the home uninhabitable.

The home was well decorated and clean when we inspected. One relative told us that the home was always, "Beautiful and spotless." We saw that the home employed cleaners who worked each day in both the communal areas and people's bedrooms.

Requires improvement

Is the service effective?

Our findings

Staff told us that they had regular supervisions, every three months. However, we looked at ten staff files and saw that supervision meetings were not regularly held. Two staff had not had supervision since 2014. Supervision records that were brief and did not support staff to carry out their role effectively. Training was not identified in the supervision we looked at and care was not always discussed. There were no appraisals in place for any staff that we checked for the past two years. Staff were not being supported to identify issues or set goals to help improve and drive good quality care.

This was in breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training records showed that staff received regular training and noted when refresher training was due for mandatory training such as manual handling and safeguarding.

Staff had a comprehensive induction when they started work. Records showed that staff completed a detailed two week induction including, being introduced to people, policies and procedures and health and safety. New staff worked with more experienced staff for a period of time before being able to work alone. One staff member said, "I did two weeks induction, I always worked with a senior carer and observed. We had to be aware of people's care plans and needs." Another staff member said, "We were taught about individuals and how important they were. Covered personal care, dignity and respect too."

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. The application procedures for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

Staff had received training in the Deprivation of Liberty Safeguards (DoLS) and The Mental Capacity Act 2005 (MCA). One staff member said, "If a resident wants to leave the building but they are not safe on their own, in their best interests you apply for a DoLS to restrict them." Another staff member told us, "People should not be deprived of what they want and if we think they are not safe we would need to apply for a DoLS." All staff we spoke with had a good understanding around DoLS and MCA in theory and practice. Staff were able to explain how MCA and DoLS impacted on the people they cared for. One staff member said, "MCA is if a resident cannot make a decision, you have to get them assessed and involve the family if appropriate."

We saw one person had had an MCA assessment. Records showed evidence of best interests meetings including the family, psychiatrist and GP. However, there were no MCA assessments for any other people in the home. Carers did not have information about the kinds of decisions people were able to make around their care. Where people were not able to make decisions, we saw that others were involved in making certain decisions. For example, where the use of bed rails was considered necessary due to the person's risk of falls it was evident that this decision had been taken in conjunction with family members as the person was not able to make an informed decision about this. However, there were no records of best interest meetings or MCA to state that the person did not have capacity.

The service had identified which people needed a MCA assessment but this had not been completed.

Four DoLS applications had been authorised. Where an application had been made, we saw evidence that the provider had followed up progress with the local authority. However, there were 38 people identified by the provider as requiring a DoLS. These had not been applied for and there were no records of best interests meetings or why they had not been applied for.

People were receiving care and treatment without appropriate safeguards, such as MCA assessments and DoLS.

This was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff requesting permission before carrying out care. One person was being transferred from a

Is the service effective?

wheelchair to an arm chair. Before the procedure staff explained what they were going to do and waited for consent before beginning. Staff talked to the person throughout the procedure and asked about the person's welfare afterwards.

People were supported to have enough to eat and drink. There was a four week rolling menu in place which offered two choices at each meal. There was also a vegetarian option. Staff told us that at breakfast times, people could request anything they liked, including full English breakfast, cereals, toast and pastries. The activities coordinator met with people during resident's meetings and asked what people wanted to eat. We saw records that this was done regularly. People told us that snacks were available. One person said, "Staff make me a sandwich if I want it." Another person said, "The food is good, there's always enough." A relative told us, "The food is excellent. My [relative] likes his food, so it's good to see he has large helpings and it's really nice." We saw that drinks were available throughout the day for people and observed staff making tea, coffee and juices. Staff were able to tell us what people's likes and dislikes were.

We conducted a Short Observational Framework (SOFI) during lunch time. A SOFI is a way of observing people and their interactions when they may not be able to tell us themselves. Food was hot when served and looked appetising. We saw that people who needed support when eating were assisted at a speed that was appropriate. Staff explained what they were doing and what the food was. People were asked if they wanted help to cut their food and staff waited for a response before assisting them. People were not rushed and asked if they had had enough to eat and drink. We observed evidence of choice. One person said that they did not want the meal that was given. The staff member asked what the person wanted and changed their meal.

Where people needed a specialist diet, such as thickened fluids or soft food, this was clearly noted and staff were aware. Where appropriate, people had food and fluid charts that were filled in daily and monitored for any changes. We saw assessments form Speech and Language Therapists (SALT's) for people and advice had been included in the care plan. Staff told us that if they felt someone was at risk with their eating and drinking or someone's needs changed they would immediately contact the SALT for reassessment.

The service regularly checks people's weights. People were weighed monthly and records were up to date. However, if there was quick weight loss the frequency was altered to weekly checks. Any people on food and fluid charts were seen weekly by the GP when they visited.

People's personal files had details of healthcare visits, appointments and reviews. Guidance given by professionals was included in peoples care plans. People were able to access healthcare with support from staff. Staff said that they knew about people's individual healthcare and how to refer people if necessary.

Professionals who visited the home told us, "Staff call us [district nurses] in promptly and appropriately. The communication between staff at the home and us is very good and staff carry out instructions that we give about people's health care." There were records of regular visits by district nurses and the care that they provided to individuals. Where necessary, guidance was carried through into people's care plans.

The home had several adapted bathrooms to accommodate people who needed support when bathing. Bedrooms were personalised with family photos, pictures and ornaments. Staff told us that when people moved in, they were able to choose the colour of their rooms. Cedars, the advanced dementia wing, was decorated like a street with people's bedroom doors imitating front doors. This allowed people to feel as if they were entering their own flats. There were 'memory windows' made to look like old fashioned shop windows, including old fashioned sweet shops, grocery stores and a wedding shop. Outside individuals rooms there were memory boxes that had people's family photos and things that meant something to them. This helped people orientate themselves to their space. Staff used the memory windows to talk with people about their life experiences. We saw one person recalling their wedding as they looked at the wedding window with a staff member. A relative said, "They [the staff] try hard to make sure their rooms are familiar."

Good

Is the service caring?

Our findings

People were treated with respect and their views about their care were understood and acted on by staff. People told us, “We are well looked after” and “Staff are kind when I want anything.” A relative said, “It’s a lovely home here, the staff are very kind and helpful.” Staff told us that they knew people well and were able to tell what people wanted by their actions if they were unable to communicate verbally. One care plan noted, ‘if [the person] turns their head away and makes a moaning noise it means they have had enough food.’

Staff treated people calmly when they became distressed or showed behaviour that challenges. We observed one person who became distressed when they did not recognise people. Staff reassured the person and sat with them until they had calmed down. We saw another person who required help when they had an epileptic seizure. Staff ensured the persons dignity and supported the person until they were able to transfer to a chair. A staff member remained with the person to ensure their wellbeing.

We asked staff how they would work with gay, lesbian and transgendered people. One staff said, “We would treat people no differently, we do not discriminate against anyone. Everyone is an individual.” Care plans had a section on ‘expressing sexuality’. Staff told us that it would be up to the individual if they wanted to discuss this area of their life and that often, people felt that this was private and the staff respected that.

Care plans noted people’s religious and cultural needs. We saw that some people were supported to attend a local church. Records showed that a priest regularly attended the home and conducted communion and blessings. Staff said that people were informed that the priest would be at the home and it was their choice if they wanted to attend. We asked if there were any other faiths catered for by the home. Staff told us that people were predominantly Christian. However, if someone with a different faith moved in they would ensure that this was catered for.

There was a good rapport between staff and people when care was being delivered. Staff knocked on people’s bedroom doors and waited for consent to enter. Staff encouraged people to be independent and asked if they wanted help. People were able to ask or indicate that they needed help and this was quickly responded to by staff. For example, we saw staff asking people "Do you need some help to go to the bathroom?" Interactions between staff and people were friendly and positive throughout the inspection.

Staff told us that they made sure that people were treated with dignity and respect. One staff said that they ensured dignity and respect when conducting personal care; “If a person is in their room having personal care, we always make sure the door is closed and curtains drawn. We talk to the resident before we do anything and explain. We must respect their choices and privacy.” Staff told us that dignity and respect was part of their induction when they started working.

Staff knew people well and we observed staff talking with people about their lives. People told us, “They [the staff] know me well”, “They remember things about me.” There was sufficient information recorded in each person’s file to enable staff to care for each person as an individual. Care files contained a personal history which described people’s background likes and dislikes and the kind of things which made them laugh or made them sad, embarrassed, angry or worried. Personal items of importance were recorded. People’s personal histories stated the name the person preferred to be addressed by. This information enabled carers to have a better understanding of the person, how they liked to be treated and what was important for them.

Relatives said that they were able to visit when they wanted to, “I visit one or two days a week, it’s never a problem.” Another relative told us, “I am always made welcome whenever I visit.” We observed family and friends visiting throughout the inspection. One person was celebrating their birthday. Staff had allocated a small dining room for family and friends and provided food. The person’s friend had brought her cat, which she had had to give up when she moved into the home. The person told us that she had “had the best day.”

There were records of regular monthly residents meetings. These were conducted by the activities coordinators and included discussions around food, people’s opinions about the care they receive activities and any house news that needed to be shared. People are encouraged to bring issues up and discuss them.

Requires improvement

Is the service responsive?

Our findings

Care plans were person centred and tailored to the individual. Care plans noted if people preferred to stay in their rooms or sit in the communal areas and the type of activity and hobbies people liked to pursue.

We saw that care plans were updated as people's care needs changed. For example one person's care plan had been updated to reflect a change in the person's mobility requiring them to begin using a wheelchair. We saw monthly reviews of people's care plans. However, in most cases the monthly review of the care plan repeated the care instructions rather than an assessment of the effectiveness of the care provided. Reviews were signed by a single member of staff and it was unclear whether the person or their representative or other members of staff had been involved in reviewing the care plan.

Senior care staff and heads of care were allocated certain people and were responsible for updating their care plans and risk assessments. They also ensured that healthcare appointments and overall care for those people were met. Staff told us that there was, "Lots of informal chats." However, there were no records that people had been consulted on reviews of their care.

For people who were unable to communicate their care plan included helpful information about them. Where able, people had signed their care plans. Where it was stated a person lacked capacity, we did not see any evidence that other people, family or healthcare professionals had been involved in drawing up the care plan. There were no MCA assessments to decide if the person had capacity.

People's waking and sleeping preferences were noted in their care plans. Staff told us that, "If people are asleep, we let them sleep. This is their home." People that we spoke with confirmed that they were able to get up and go to bed when they wanted. One person's daily records noted that the person had got up during the night and wanted to doze in the lounge. Records showed staff supported the person to do this and checked on them at regular intervals. One care plan noted, '[The person] likes to get up between 8 and 8.30am and can become a little upset if the assistance is not on time'.

The home had two activity coordinators. There was an activities timetable on the hallway notice board that listed daily activities for mornings and afternoons. The activity coordinators told us, "We book lots of external entertainment, and the residents love it. We do lots of themed events here. We recently had a Halloween party, and visited the Aircraft museum at Hendon, which the gentlemen all liked". One person said, "'I have enjoyed the outings. I've been to Southend, the RAF Museum and network house. We all got drenched that day but it was a good laugh.' We saw that all people who attended external activities had specific risk assessments completed for the activity they were undertaking. The home has its own mini bus which is used for external activities. If an activity was popular it would be run twice to ensure that everyone who wanted to attend would be able to.

We observed an entertainer that visits the home regularly on day one of our inspection. The event was well attended and people were encouraged to join in. People were laughing and smiling and staff supported people to gently dance if they were able. We also saw that where people did not want to be involved, they were able to leave the area and go to a quiet lounge or their bedroom. We saw photos, and people told us, that the activities coordinators had put on a Victory in Europe (VE) day celebration and recreated a traditional street party. There were regular arts and crafts groups and movement classes involving gentle movement to help keep people fit.

On mothering Sunday, people were encouraged to write their memories of their mothers or family life. These were laminated and hung along the staircase. We saw a small memory tree in the hallway where people were encouraged to write the names of loved ones that had passed and hang them on it. People were encouraged to talk about their lives and one person told us, "I remember when I was young; they let me remember that, I don't remember much else."

The home had a hairdressing room. A hairdresser comes in on Mondays and Wednesdays. People are able to book appointments and staff support people where necessary.

The home had a very large, well-appointed garden at the rear. There was a small orchard and staff told us that some people go with family members to collect apples, pears and plums, when they are in season. The cook then makes pie or crumble for the home. The advanced dementia wing had a separate entrance onto a patio that over looked the garden. This contained a sensory garden. Each person had individual raised beds that they helped grow and take care of.

Requires improvement

Is the service responsive?

The home had a house cat. People said that they liked having a pet within the home. One person said, “It makes it feel more homely.”

Relatives told us that they were aware of how to complain if they needed to. One relative said, “They told me how to complain if I needed to but I haven’t need to so far.” All people were provided with a welcome pack when they moved in. This included information on how to complain.

There was a poster in the hallway of the home that informed people of the process. People were reminded of the complaints procedure in residents meetings. Complaints were logged in a complaints file. There was one complaint from January to November 2015. There was no follow up noted or evidence that the provider had dealt with it effectively.

Requires improvement

Is the service well-led?

Our findings

The registered manager had left the week that we inspected. The provider's operations manager was present during the inspection along with one of the heads of care at Woodbury Manor. The provider planned to advertise for a new manager as soon as possible.

Staff told us that they felt the home had an open atmosphere. One staff member said, "I do feel supported by the management team, and I feel that I can raise anything with them". Staff that we spoke with felt that they were able to raise ideas and that they would be listened to. Staff also said that they felt that the home had a shared view on the quality of care. One staff member said, "We are always told that the residents come first here, it's a family atmosphere, and we always try to make sure of that." During induction staff were trained in the values of the organisation. Training records showed that staff were encouraged to maintain and update care skills and knowledge. Staff that we spoke with were able to tell us how they had put their training into practice.

We found that documentation such as MCA assessments, applications for DoLS and comprehensive recording of complaints was not in place. No staff had had appraisals and regular supervision meetings were not held. There had been no audits by senior staff to ensure that these were completed.

We saw that there were monthly audits, completed by the head of care, around incidents and accidents and maintenance. A separate audit was completed for falls. There was evidence that information from these audits was used to improve the quality of care for individuals and the service overall. No medicines audits had been carried out.

Complaints were not well documented and outcomes not evidenced. There was no evidence that information was used to drive improvements in quality of care.

This was in breach of Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed detailed annual surveys with people and relatives. These looked at food, personal care and support, management and daily living. An action plan had been created following the survey allowing the provider to address areas of concern and improve quality of care for people. The surveys were available for people and relatives to see.

Team meetings were not held regularly. One team meeting had been documented within the last year. The head of care told us that team meetings had taken place more regularly but had not been documented.

A relative told us, "If there are any issues, the management is good at letting us know and giving the right response."

Records showed joint working with the local authority and other professionals involved in people's care. The head of care told us that they work closely together to make sure that people received a good standard of care. One healthcare professional told us, "The home is very good at contacting us and keeping us up to date."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People had not been assessed under the Mental Capacity Act. DoLS had not been applied for 38 people identified by the provider as requiring one. **Regulation 11(1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People had not been assessed for personal evacuation plans (PEEPS) in case of fire. **Regulation 12(2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered provider failed to ensure that complaints received had been investigated and necessary and proportionate action taken. There were ineffective systems in place to deal with complaints. **Regulation 16(1)(2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not received regular supervision. There were no appraisals in place for any staff for the past two years

This section is primarily information for the provider

Action we have told the provider to take

Regulation 18(2)(a)