Ridgewood Care Services Limited

Woodcote

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

Overall summary

This inspection took place on 18 June 2015 and was unannounced.

Woodcote is a privately owned residential care home providing care and en-suite accommodation for up to six people with a learning disability. They specialise in autism, challenging behaviour, epilepsy, hearing and speech impairment. Five people lived in the home at the time of our inspection. Most of the people living in the service were able to express themselves verbally, others used body language.

There was not a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People said they felt safe living in the home and relatives told us that their family members received safe care. Staff understood how to appropriately report and respond to any allegations of abuse.

Safe recruitment procedures ensured that staff were suitable to work with people. Staffing levels were based on people's needs and promoted their safety and wellbeing.

Summary of findings

People had individual risk assessments for all areas of their living activities. These were updated or reviewed when people's needs changed.

Medicines were stored and administered safely so that people received the medicines they needed. People who wanted to and had been assessed as safe to do so managed parts of their own medicine administration and recording to develop their independence.

People received medical assistance from healthcare professionals including district nurses, opticians, chiropodists and their GP.

Staff had the necessary skills and knowledge to ensure they could meet people's complex needs. Staff had received the training they needed to enable them to carry out their roles effectively.

We observed that staff sought people's consent before providing care and support. Staff and management understood the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Assessments of people's capacity to make decisions had been carried out in line with the MCA requirements.

Staff were respectful and caring in their approach. People were given the support they needed to ensure they had meaningful occupation and their social needs were met. People's choices were respected and staff supported people to take part in activities that suited their individuality.

Staff responded to people's behaviours that challenged with insight, patience and care. People's communication needs were respected and met to ensure they could express themselves and be understood.

People were supported and encouraged to maintain links with family and friends.

There was a complaints procedure in place. Information about how to complain was displayed in the entrance lobby in pictorial format so that people knew how to make a complaint.

People and their relatives felt the home was well run and were confident they could raise concerns if they had any. There were systems to assess and monitor the quality and safety of the services provided and to recognise when improvements were needed and to act on these.

At our last inspection in May 2013 no concerns were found.

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?
The service was consistently safe.

Staff were trained to protect people from abuse and harm and knew how to refer to the local authority if they had any concerns.

Staff numbers were adjusted according to people's needs.

Risk assessments were updated appropriately to ensure that staff had clear guidance in order to meet people's needs.

There were safe recruitment procedures in place to ensure that staff working with people were suitable for their roles.

Good

Is the service effective?
The service was consistently effective.

Staff had received training and supervision relevant to their roles. Staff felt they received good support from their manager.

Staff and management had a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were provided with adequate nutrition of their choice.

People were promptly referred to healthcare professionals when necessary.

Good

Is the service caring?
The service was caring.

People told us they found the staff caring, and that they liked living at Woodcote.

People were treated with patience, dignity and respect.

Staff respected people's right to independence and supported them to achieve it.

Good

Is the service responsive?
The service was consistently responsive.

People's care was personalised to reflect their wishes and what was important to them. The delivery of care was in line with people's care plans.

People knew how to make a complaint and were given opportunities to give their feedback. Relatives told us they were kept well informed by the staff.

People had their social needs met and were supported to maintain links with their families and the community.

Good

Is the service well-led?
The service was consistently well led.

Good

Summary of findings

There was an open culture that focussed on people. Staff felt supported and were confident that they could discuss any concerns with the manager.

People who used the service and their relatives felt the staff and manager were approachable.

There were systems to assess and monitor the quality of the services provided and improvements were carried out as a result.

Woodcote

Detailed findings

Background to this inspection

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

The inspection team comprised one Inspector and one bank inspector.

This inspection took place on June 18 2015 and was unannounced.

Before our inspection we reviewed information supplied to us by the acting manager in a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We also looked at records that were sent to us by the manager or the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

We spoke with four people who lived in the home and four of their relatives to gather their feedback. We spoke with the registered manager and three care staff. We also spoke with two health professionals about their experience of the home.

We looked at records which included those related to four people's care, staff management, staff recruitment and quality of the service. We looked at people's care plans and undertook observations to check that the support provided was consistent with their assessed needs. We looked at satisfaction surveys that had been carried out and through the provider's policies and procedures.

Good

Is the service safe?

Our findings

People's relatives told us they felt their loved one was safe at Woodcote. One told us, "X is definitely safe. I have no worries or concerns." One relative told us, "X is safe. They see their GP regularly and there are plenty of staff to look after them." There were sufficient staff to keep people safe. On the day of our inspection there were three staff to support the five people living there. At night there was one waking staff and a provision for an extra sleep-in staff if there were any additional concerns or support needs.

Staff had a good understanding of what constituted abuse. All staff had completed training in safeguarding people from abuse and received regular refresher training. The provider had a policy to refer to which told staff how to report allegations of abuse. Staff knew how to contact the local authority should they have any concerns about people's safety. People all had appointees or someone with Power of Attorney (POA) who worked with people and the home to oversee their finances. For example one person who was supported to manage their own money had their finances checked and signed for daily and audited monthly by the provider and annually by an external, independent body. This helped to protect people from the risk of financial abuse while promoting their independence. Staff were aware of the provider's whistle blowing policy and told us they would feel confident and safe in reporting any issues.

There were risk-based individual guidelines for staff to use regarding people's safety during specified activities such as visits to the home's pond, using a trampoline, car outings and shopping in the community. Risk assessments were carried out when people went swimming, bathed or used the kitchen appliances. All risk assessments contained clear guidelines for the staff to follow so that risks were minimised. The staff understood the risks people faced and the actions they needed to take when they supported or cared for them. Staff were trained to keep people safe when they presented with behaviours that challenged. The provider had a policy of not using any form of restraint. This meant that staff were able to support people to undertake a variety of activities safely while using the least restrictive options.

All staff had received behaviour de-escalation training and care plans indicated signs and triggers for people's different behaviours. Staff were familiar with these and demonstrated good understanding and knowledge of each person's needs in the home. They told us, "People are safe because we know where people are all the time, we're lucky with the grounds too." The high staff to people ratio meant that there was always nearby. The gardens were accessible but secure.

Staff were all trained in emergency first aid and fire procedures and received regular refresher training. Fire equipment in the home was serviced regularly by a contractor. Fire exit signs were displayed in an appropriate format so that people could understand them. There were annual full evacuation fire-drills and weekly fire-alarm tests. People in the home had been actively involved in recent fire evacuation training.

The acting manager completed monthly health and safety environment checks. Any areas requiring attention were noted and passed to the maintenance team to deal with. These were signed off with a completion date. There was a contingency plan to house people in a sister home in the case of any emergency such as fire or flood. This meant the premises and equipment were managed so that people were safe. People's care plans included an identity sheet with details of emergency contact numbers and photograph, ready to be provided to emergency services if necessary.

Monitoring and analysis of accident and incident reports formed part of the home's quality monitoring audit. Antecedent, Behaviour and Consequence (ABC) charts were used for recording all incidents of behaviour that challenged. These were analysed to identify triggers so that people could be supported appropriately with the aim of helping them reduce their challenging behaviour and therefore, the risk to themselves and others.

Relatives told us, "There are enough staff so that there is always someone available." On the day of our inspection there were three care staff and the acting manager. Staff rotas confirmed this was the norm with one waking night-time staff. There was always another staff member on call at night if necessary and the home organised a sleep-in staff support at times when people appeared unsettled. The registered manager used a dependency tool to work out safe staffing levels. They reviewed the care needs for people whenever their needs changed to determine the staffing levels needed and increased staffing levels

Good

Is the service safe?

accordingly. The number of staff on duty matched the allocation on the staff rota on the day of our inspection. This meant that people were safe because staffing levels were sufficient to meet their individual needs.

The provider operated safe recruitment procedures to make sure staff were suitable to work with people at Woodcote. We examined staff recruitment systems and examined five staff files. These all contained at least two forms of personal identification, two relevant references, a record of interview, a copy of the staff member's contract, details of their induction training and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with adults. Gaps in employment history were explained. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. Staff all signed to acknowledge receipt of the provider's code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

People received the medicines they needed when they needed them. Medicines were safely stored, recorded and administered by suitably trained staff. One person was supported by staff to self-medicate and complete their own Medication Administration Record (MAR) sheets as this increased their independent living skills. This was monitored by staff to support the person to continue to safely take their medicines as prescribed. Two other people who took their own medicines in the evening were monitored by staff who then countersigned their MAR sheets. Medicines were given safely and staff were patient when giving them. All medicines were stored safely and clear, accurate records were maintained of each person's medicines.

Challenging behaviour guidelines described known behaviours and triggers. This contained clear guidance for staff about management of behaviour that challenged. This was cross-referenced with as required (PRN) medicine guidelines. There were up to date signatures from all staff to show that they had read these and knew how to meet people's individual needs. The staff we spoke with were able to describe the steps they would take in relation to people's behaviour and PRN medicines. As staff followed appropriate guidance, people could be confident they were cared for safely.

Staff had completed infection control training and there were plentiful stocks of disposable gloves and aprons available for staff as well as antiseptic hand wash dispensers. Staff wore these whenever they provided help with personal care or prepared food. People were encouraged to wash their hands appropriately. Suitable systems were in place in the kitchen to ensure that food was prepared in a hygienic environment. This meant that people were protected from the risk of infection.

Good

Is the service effective?

Our findings

People told us that Woodcote provided effective care for their loved ones. Relatives told us, "There is very good food. X likes his food" and "X has good access to the GP regularly." Another told us, "X sees the dentist regularly."

Staff told us they received a thorough induction which included becoming familiar with all care plans and getting to know their 'key person' to gain a detailed knowledge of the person, their needs and aspirations. One staff told us they attended various training courses in the last six months, including food safety, behaviours that challenge, medicine administration, safeguarding, and the principles of the Mental Capacity Act 2005 (MCA). They also completed a course about supporting people with learning disabilities. Staff training sometimes took place within staff meetings or via external on-line training and included elements from the new Care Certificate which was introduced in April 2015. This care certificate is designed for new and existing staff and sets out the learning outcomes, competencies and standard of care that care homes are expected to uphold. Staff told us they felt empowered by their training and able to provide effective care as a result.

The acting manager had ensured staff received monthly one to one supervision and staff told us they valued this support. One member of staff told us, "It's really good, they find out if we're happy and we need to know they are happy with what we're doing. We have a whole hour and can discuss any issues about service users or staff. Everyone needs that, don't they?" Staff all received annual appraisals where their performance and training needs were reviewed and discussed. This ensured that people were supported by staff who had the skills and knowledge to meet their assessed needs.

Care plans included detailed descriptions of people's communication levels and support needs. There were also practical guides about achieving the best communication with each person. One person's care plan stated, "Communicate slowly and exaggerate movements to facilitate their ability to lip-read." This method was used by staff. All staff also knew basic Makaton sign language and some people were happy to communicate using this while others preferred to write or use pictorial aids. One person was not able to communicate verbally and made themselves understood by sounds and actions. We saw that staff knew the person well and were able to communicate with them effectively.

There were menus in a pictorial format to allow people who could not read to express their choices clearly. Care Plans included a communication passport with a positive interaction profile. This detailed the best way to work with the person to support them by effective targeted communication, for instance, "Use short simple sentences, stress key words, back up with objects of reference." The staff had referred people to the Speech and Language Therapy (SALT) team and their guidelines were included in care plans and known by staff. The provider had arranged for all staff to be trained in Makaton sign language and this was on-going. Makaton is an adapted sign language based on British Sign Language for use by people with learning disabilities and those that know and support them. Where people were able to communicate effectively through writing there was evidence through their care plans of this, such as completed MAR sheets and signed indications of involvement in reviews. This showed that steps were taken to involve people in decisions about the support they received.

Each person in the home had their own keyworker. A key worker is a named member of staff with special responsibilities for working closely with a person, to build a special rapport and understanding and work with them to achieve the best possible outcomes. There were monthly team meetings which included discussing people's needs, concerns and progress with other members of team. Staff said this helped, they told us, "So we're all up to date and know what we are each doing." Staff described sharing and communications within the team as very good, saying they relied on each other's records, and communication on shift.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Whilst no-one living at the home was currently subject to any DoLS restrictions, we found that the manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty.

These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being

Good

Is the service effective?

required to protect the person from harm. Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005(MCA) to ensure any decisions were made in the person's best interests. Assessments of people's mental capacity had been carried out appropriately, and when necessary meetings had been held to decide the way forward in people's best interest. Staff had all received training and were clear about the principles of the MCA.

The staff we spoke with understood the importance of obtaining consent from people before care or support was provided. They were checking with people that they agreed before they provided support. They were aware that a person's ability to consent could change and respected people's right to decline. Staff told us, "While people may not be able to communicate verbally they can clearly demonstrate whether or not they want to do something."

Cooking was carried out in the home by staff and people were involved in the planning of menus People with eating difficulties were supported by the involvement of the Speech and Language Therapy Team (SALT) to be able to eat a healthy and nutritious diet. This involved having special soft food, and meals cut up into small portions. One person had a fridge in their room which contained their juice and drinking water. People told us they were able to make themselves drinks or snacks whenever they wanted. This meant that people had access to a varied diet of their choice.

One person told us they saw their GP regularly and went to their dentist in a nearby town. There was a daily diary with people's GP and other external health related appointments so that staff had a quick and easy reminder to ensure people kept these and were supported to maintain good health. The medicine's appointment record showed that in response to difficulties accessing the Community Learning Disability Team (CLDT) for a medicine review, a GP appointment was obtained. We saw records of dental appointments with forward treatment plans as well as records of opticians' appointments. There were sensitive guidelines regarding continence management, describing reasons, triggers and practicalities such as the use of pads and support from continence nurses. People we spoke with had a good understanding of their medicines and their effect. People told us that they had specific health needs and they were supported with these needs. They said they had regular appointments with health professionals such as chiropodists, dentists and opticians.

Good

Is the service caring?

Our findings

People at Woodcote were supported by staff who made them feel cared for and promoted their independence. One person told us, "I love it here." Another told us, "I can get the bus up the road into town - I go on my own." Relatives said, "Very good staff. They're helpful, kind and supportive."

The home presented as homely, with plenty of room for people to find personal space or to socialise. The kitchen was fully accessible to all people in the home, and used by them for making hot drinks and assisting staff in meal preparation.

People were at ease with all the staff. They appeared to have good relationships with them. Staff were patient and spoke kindly to people. They knew people and their personalities well and this was apparent in interactions we observed. When one person was eating we saw staff sitting with them and chatting about their plans for the day and encouraging them with their eating. When one person went into the manager's office they were encouraged to stay and converse with them. They appeared satisfied that they had been listened to and further interacted with staff in a positive way. We observed staff starting conversations with people in a friendly, sociable manner and not just in relation to their tasks. They gave people time, answered their questions and listened attentively to what they said. People and staff were smiling, joking and laughing through many of these conversations. One person was in the kitchen whilst she was getting a drink for herself and another person. They told us they felt at ease with all the staff, and saw them as helping individuals and "Helping keep things calm between the people who live here."

Care plans were personalised and had clear evidence of people's involvement in creating and updating them. Where people were able they had signed to show their agreement to changes. Pen portraits were written in the first person and gave a real sense of the person's history, individuality and personality. Sections were presented in pictorial formats when this was appropriate. One person's care plan included their contract in terms of what they had to buy for themselves and what was provided through funding. This had been written using specific key words they responded to and was accompanied by an easy read version in pictorial form.

People had various ways of communicating and we saw staff interacting and explaining what support they were providing or where they were taking the person patiently and kindly until they indicated their understanding and agreement.

There were meal time guidelines for staff around positive behaviour reinforcement and there was guidance for promoting positive interactions with people. The dining room was very homely and there was a live-in pet dog. Observations during the day confirmed staff were skilled in reinforcing positive behaviour, as did the ease with which residents were able to engage with us as visitors to their home. Guidelines in care plans also considered people's personal choice, independence and encouraged staff to support people to carry out activities at their own pace.

All rooms were en-suite which promoted both independence and privacy. A shared bathroom had a specially adapted bath to support people with mobility difficulties. One person's en-suite door had been replaced by a removable curtain to address a cleaning issue whilst preserving their dignity.

People were supported to be independent. One person wished to have a key to their room and this was facilitated. Another person went on holiday with their parents this year. They also went into a nearby town on the bus on their own. Staff told us they picked him up and dropped him off at the nearby garage just a short walk from the bus stop to facilitate this. One person was supported by staff with their finances every week. They independently bought DVDs, toiletries and snacks to keep in the fridge.

Another person told us they liked to walk the dog. Relatives told us that they felt the home was very good in promoting people's independence. One said, "He has his own key to his room and very helpful staff." Key worker records within care plans showed that people participated in the home and daily living activities and were encouraged to do as much as possible for themselves.

We saw in care plans that people's end of life care wishes had been discussed with them by way of a series of discussions. One person's end of life wishes were detailed about the type of funeral they wanted including the music they wanted played and their choice of venue.

Good

Is the service responsive?

Our findings

People's care plans included a pre-admission assessment that included a detailed account of their individual needs such as personal care, health and communication. There was also information regarding behaviour patterns, sociability and levels of independence. People's preferred leisure activities were included, for example, "Enjoys Pilates and swimming." One person's pre-assessment stated, "Independent in personal care. Will need support with behaviour management, managing money and community access." These assessments were followed by the provider's own assessment once the person had settled in and staff had got to know them.

Care plans highlighted the person's strengths and support needs in various areas such as independence, behaviours, personal care and communication. Areas where regular reviews were considered as needed to check they remained up to date and still met people's needs had been identified. Keyworker reports were included to monitor people's progress and achievements. People's behaviour was recorded in detail as an indicator of their well-being including aspects such as increased activity, tiredness, mood states and sociability. Behaviours that challenged were being recorded in more detail including times and places and other people present including staff, to allow useful analysis. In the case of one person this led to the implementation of an increased activity plan which in turn significantly reduced the number of incidents of behaviour that challenged. This improvement was noted and used to inform the planning for the following month.

Care plans included robust and detailed guidelines to staff for managing behaviour that challenged. These gave clear steps for staff to respond to situations and to minimise the impact of behaviours on the person as well as additional guidelines for how to re-direct and focus the person on positive behaviours. Staff had in-depth knowledge of these guidelines and this was put into practice during our inspection. Incident reports indicated that staff were acting in line with the guidelines. Newly recruited staff were able to deal with behaviours appropriately and record good outcomes. These guidelines were also cross-referenced in other relevant sections of the care plans such as risk assessments.

Key workers held a review of people's care every month and this included whether their medicines remained appropriate and whether people required support or were able to take their own medicines.. They also included monthly weights, sleep patterns and social needs, for example if external activities had increased One person had been wandering into other people's rooms at night. Following discussion with the person and their family the provider had arranged a move to a downstairs room and this had significantly reduced the frequency of such incidents. People's involvement in planning their activities was recorded and notes made about steps taken to facilitate people's wishes. For example one person had written that they wanted to attend "deaf club" and the key worker had written, "need to investigate," as a response. Staff told us this was being followed up and discussed to decide what support would be needed to achieve this.

After the keyworkers and people had met to review the plan of care they were checked and audited by the registered manager. Individual goals were considered and reviewed with people. These included activities towards people's ability to live independently such as using the washing machine, doing their own ironing and shopping. One person told us, "Staff tell me how I'm getting on and this has been a good place to live." One person was actively involved in planning and organising their holiday to Disneyland. People went out daily and one person told us, "My favourite things are going to the park and McDonalds." People told us they were involved in decorating their rooms and liked the fact that they could choose to stay in their rooms or mix with the others. One person told us, "I have been out to Pilates this morning. I'm very tired but it was good." They also told us they were looking forward to their birthday party soon which they had been involved in planning. The care plans included a section where people were encouraged to write what they had particularly enjoyed doing each month. People's answers included a cinema trip, a birthday party and a new library class. This showed that staff responded to people's requests and supported them to take part in their chosen activities.

There was an activity planning board in the hallway which showed that activities were planned twice daily, with at least one daily activity involving community access. The home had a seven seater vehicle so that they could take everybody out with two support staff. Relatives told us they were pleased with the number of activities available. One person was supported to work locally in a shop. There had been a recent picnic on a nearby beach. One person chose not to participate in Pilates as they didn't like joining group

Good

Is the service responsive?

activities. The home had arranged one-to–one sessions with a personal trainer for them. All these activities helped reduce the risk of people becoming socially isolated and responded to their individual needs and wishes.

People took part in weekly planning meeting for activities where they had chosen swimming, walking, bowling, meals out, reflexology, 'cook and eat' parties, arts and crafts, health and beauty, library club and talking books. Relatives were always welcomed at the home. The provider organised group psychology as part of family visits. One person went home regularly and spoke to their family by phone daily. Some people were funded by the home for college courses including 'cook and eat' and music therapy.

There were regular house meetings where people discussed things they wanted to do and buy and they were supported by staff to achieve these. We saw minutes from monthly resident meeting and monthly staff meetings.

People told us that their suggestions were listened to and actioned, for example getting a pet dog for the home had been their choice. A monthly questionnaire was sent out to people. Relatives we spoke to had received the questionnaire. People told us they were happy with all aspects of the service. They said, "There's nothing to complain about there," and "I can't imagine wanting to complain about anything." There was a complaints policy and procedure and each person was given a copy when they moved to the home. This procedure explained to people how to make a complaint and the timescales in which they could expect a response. There was also information and contact details for other organisations that people could complain to if they were unhappy with the outcome. With this system in place, people could be confident that their feedback was taken into account and that the manager would respond to any complaint they might make.

Good

Is the service well-led?

Our findings

Relatives were complimentary about all aspects of the service. Relatives told us they had a very positive relationship with the manager. They told us the manager and staff were approachable and the management team often chatted with them and asked them how things were. One person said, "They are all wonderful." People described Woodcote as, "Very homely."

We saw the home's policy file was signed by all staff to show that they had read it. This included detailed information about behaviours that challenged and de-escalation techniques. Staff were knowledgeable about both the provider's ethos for the home and the policies. The home had been accredited by the Gold Standards Framework for End of Life Care since our last inspection. The accreditation process involved continuous assessment against 20 standards of best practice across a two year period and an official inspection visit at the end. Staff were confident and well informed about all aspects of end of life care. People at the home who nearing end of life were assured of sensitive and effective care in line with best practice.

The provider had clear vision and values in relation to the service they provided. The ethos of the home was to follow O'Brien's five principles of ordinary life; choice, respect, dignity, community presence and community participation. There were both written and pictorial versions of the provider's statement of purpose on display. Staff were familiar with these principles and we saw it translated into practice during our visit and in care plan records of best interest meetings and innovative and valid ways of confirming consent.

Staff told us that the acting manager was very approachable and understanding. She had moved her office from the first floor to the ground floor to make herself more accessible to people and staff. People were welcomed into the registered manager's office and they took time to listen and respond to people. Staff said they were encouraged to raise issues or make suggestions and felt they were listened to. Regular staff meetings were held to make sure staff had opportunities to share their views and keep up to date with any changes.

There were systems in place to review and monitor the quality of all aspects of the service. The provider carried out regular audits of the service and improvement plans were developed to ensure the quality of the service was continually improving.

Audits that were carried out monitored areas such as infection control, health and safety, care planning, accidents and incidents, staff training and medication. Quality monitoring reports were completed monthly and included an audit of meetings and care plans. When shortfalls had been identified, action had been taken. One result of this process was that a more robust analysis of accidents and incidents now took place which allowed action to be taken to prevent recurrence. Records showed that appropriate and timely action had been taken to protect people and ensure that they received any necessary support or treatment. The registered manager of the home told us that they were helped to carry out their roles effectively by the support of the provider.

Staff told us that the acting manager led by example and had an open door policy. They also told us that the team meetings were good, they were 'listened to' and their supervision was a positive experience. The acting manager told us, "I have a good team who are dedicated to providing the best lives possible for the people who live at Woodcote." Questionnaires had been sent to relatives of people living at Woodcote as well as GPs and the results were available for us to see. The results were analysed and demonstrated that people had a high regard for the support provided to people living at Woodcote.