Nellsar Limited

Woodstock Dementia and Residential Care Home

Inspection report

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Date of inspection visit:
28 June 2016

Date of publication:
03 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 28 June 2016 and was unannounced.

Woodstock Residential and Dementia Care Home is located on the outskirts of Sittingbourne in a quiet residential area. It provides residential care for up to 55 older people including those people with a diagnosis of dementia. It consists of two units and provides mainly single accommodation with some shared rooms. Accommodation is set over two floors and there is secure access to a garden area. At the time of our visit, there were 44 people who lived in the home. People had a variety of complex needs including communication difficulties, physical health needs and mobility difficulties.

There was a registered manager at the home. 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's care plans contained information about their personal preferences and focussed on individual needs. However, people's care plans had not been updated with up to date information about their changing needs and staff had not effectively responded to one person's needs based on a healthcare professional's guidance.

People were protected against the risk of abuse. People told us they felt safe. Staff recognised the signs of abuse or neglect and what to look out for. Both the registered manager and staff understood their role and responsibilities to report any concerns and were confident in doing so.

The home had risk assessments in place to identify and reduce risks that may be involved when meeting people's needs such as physical disabilities, falls and details of how the risks could be reduced. This enabled the staff to take immediate action to minimise or prevent harm to people.

There were sufficient numbers of staff to meet people's needs. Staff had the knowledge and skills to meet people's needs, and attended regular training courses. Staff were supported by their manager and felt able to raise any concerns they had or suggestions to improve the service to people.

Staff were recruited using procedures designed to protect people from unsuitable staff. Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe medicines management processes were in place and people received their medicines as prescribed.

Staff encouraged people to undertake activities and supported them to become more independent. Staff spent time engaging people in conversations, and spoke to them politely and respectfully.

People's care plans contained information about their personal preferences and focussed on individual needs. People and those closest to them were involved in regular reviews to ensure the support provided continued to meet their needs.

Systems were in place to enable the registered manager to assess, monitor and improve the quality and safety of the service.

The food menus offered variety and choice. They provided people with nutritious and a well-balanced diet. The chef prepared meals to meet people's specialist dietary needs.

People were involved in their care planning, and that staff supported people with health care appointments and visits from health care professionals.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People spoke positively about the way the home was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

During this inspection, we found a breach of regulations relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had taken necessary steps to protect people from abuse. Risks to people's safety and welfare were assessed and managed effectively.

There were effective recruitment procedures and practices in place and being followed.

There were enough staff employed to ensure people received the care they needed and in a safe way.

Medicines were managed and administered to people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always supported effectively with their health care needs.

Staff had received regular supervision from their line manager to ensure they had the support to meet people's needs. Staff had undertaken key specialised training courses required to adequately meet people's needs.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and relatives were included in making decisions about their care.

The staff in the service were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the home to make sure that the staff could meet their needs.

The management team responded to people's needs appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The home had an open and approachable management team.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There were systems in place to monitor and improve the quality of the service provided.

Woodstock Dementia and Residential Care 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 28 June 2016 and was unannounced.

Our inspection team consisted of one inspector, a specialist advisor who is a dementia care nurse and one expert-by-experience. Our expert by experience had knowledge, and understanding of residential services and of supporting family and friends with their health care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the home, which the provider is required to tell us by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with eight people, six visiting relatives, two health care assistants, one team leader, the activity coordinator, deputy manager and the registered manager. We spoke with a visiting healthcare professional and also requested information from other healthcare professionals involved in the home. These included professionals from the community mental health team, care managers, continuing healthcare professionals, NHS and the GP.

We looked at the provider's records. These included five people's records, which included care plans, health care notes, risk assessments and daily records. We looked at five staff files, a sample of audits, satisfaction surveys, staff rotas, and policies and procedures. We also looked around the care home and the outside

spaces available to people.

At our last inspection on 19 August 2014, we had no concerns and there were no breaches of regulation.

Good

Is the service safe?

Our findings

Our observation showed that people were safe at the home. People made comments as follows,, "No problem, there is enough staff to help everyone. They are always working very hard", "I am safe here. The front door is locked and there are lots of staff who look after you very well" and one person who recently moved into the home said, "Very good so far. The staff looks after my wife and I well. We are safe here. Here I don't worry, there are staff 24hrs a day and the front door is locked. We both sleep very well. The night staff pop in to see if we are okay".

Relatives felt their family members were safe in the home. One relative said, "She is well looked after here. I know she is safe. She likes all the staff". Another relative said. "Yes, she is safer here. She was having frequent moods at home and we couldn't cope with her at home, she doesn't seem to get the moods here. I am so happy now that she is here".

Healthcare professionals commented, 'To my knowledge they do receive safe care', 'I have not come across any usual practice during home clinic, staffs seem to be aware of the needs of their client and take appropriate action such as contact to the care manager or discuss alternate intervention that would help the staff to care for the client effectively in the care home' and "I have been coming here over 10–11 years and I have never left here believing to raise a safeguarding".

People were given their medicines in private to ensure confidentiality and appropriate administration by the registered nurses responsible for medicine administration in the home. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. We observed senior staff administering people's medicines during the home's morning medicine round. Staff checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely. The staff discreetly observed people taking their medicines to ensure that they had taken them.

Medicines were stored safely. There was lockable storage available for stocks of medicines. There were medicine trolleys, which were locked and secured to the wall. The medicine fridge was locked and a record had been kept of the fridge temperatures, to make sure that medicines were stored safely. The contents of the controlled drugs cupboard and register were checked and these records were accurate.

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. Fluid thickener, which was used to thicken drinks to help people who have difficulty swallowing, was kept locked away in the cupboard in another locked storage room for safety. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. The registered manager and deputy manager conducted a monthly audit of the medicine used. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues.

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training within the last two years. The staff we spoke with were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. They said that they had completed safeguarding training prior to and after taking up their post in the home. They said that this training was updated each year. Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The home had up to date safeguarding and whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

There were suitable numbers of staff to care for people safely and meet their needs. The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times. We also observed that there were sufficient staff on duty to meet people's needs, for example supporting people attending hospital appointments on an individual basis. The registered manager said that if a member of staff telephones in sick, the staff in charge would contact their bank staff team to find cover. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the roster is based on the needs of people. Staffing levels were regularly assessed depending on people's needs and occupancy levels, and adjusted accordingly. This demonstrated that both the provider and registered manager had staffing levels based on people's needs in order to keep them safe.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. This meant people could be confident that they were cared for by staff who were safe to work with them.

People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were specific to each person. Staff told us they were aware of people's risk assessments and guidelines in place to support people with identified needs that could put them at risk, such as diabetes. However, in one person's care records out of the five we looked at, we found

no risk assessment on diabetes, which is vital to the management of diabetes. We informed the registered manager during feedback and this was immediately put in place. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. This ensured staff had all the guidance they needed to help people to remain safe.

We spoke with both the deputy manager and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The deputy manager described the action they had taken to minimise the risk of falling for one person who had had a number of falls. There was a clear plan in place which staff were aware of and used.

Accident and incident forms were completed when people were involved in accidents such as falls. Details of people's injuries were documented and any action taken was recorded. Other information included which staff were on duty at the time, who witnessed the incident, any further action needed and who was informed and when. The records contained body maps which showed where on the body people had sustained their injuries. Outcomes of investigations were documented with any action needed to minimise the risk of the incident happening again set out.

Emergency Evacuation Plan was seen on the reception notice board. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was recently reviewed in 2016. Fire equipment was checked weekly and emergency lighting monthly. Staff had completed a fire competency assessment.

There was a plan for staff to use in the event of an emergency. This included an out of hour's policy and arrangements for people which was clearly displayed on the notice board. This was for emergencies outside of normal hours, or at weekends or bank holidays. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with all foreseeable emergencies.

The design of the premises enhanced the levels of care that staff provided because it was specious, well decorated and had been suitably maintained. Corridors were spacious with good lighting and were very clean and fresh.

Requires Improvement

Is the service effective?

Our findings

One person said, "There are no restrictions. I go out for lunch with my son. We've had a BBQ in the garden everyone was invited. It was a lovely day". Another said, "Good food. They feed you well, lots of vegetables" and "I am having a sandwich today instead of prawn salad. We are always given a choice".

One Relative said, "Staff seem to know what they are doing. When she pulled out her catheter they called the rapid response nurse immediately. They always keep me informed". Another said, "Staff well trained. They handle her properly. Look after her well".

A healthcare professional commented, 'Yes, the management do contact myself or the service for any issues that they have a concern with and communicate effectively of their needs'.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. Records of allergies were kept in people's care plans and medicine records. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians.

However, for one person who was diabetic, we found that on 11 November 2015 the person was referred for a nutritional assessment at NHS Medway Community Health (MCH) because of a sudden loss of 4kg in weight over 14days. On 26 February 2016, MCH carried out a further nutritional review and the person was discharged with the following clinical advice and plan, 'weight and MUST screening should be completed at least monthly, more often if concerned and the patient should be re-referred to the dietetic service if the MUST score is 2 or higher.' A MUST score is a 5-step screening tool for adults at risk of malnutrition or obesity. A body mass index (BMI) score using height and weight is preferred for accuracy of the measurement. The person's weight on discharge from MCH was 66kg, BMI was 25.8 (normal ratio being 18.5 - 25). The following dietary advice from MCH was documented, 'It is recommended the patient have a fortified diet with extra butter/cream/cheese/sugar added to meals and high calorie snacks and fluids regularly'. Woodstock's own nutritional assessment gives this lady a score of 2, meaning she is deemed at moderate risk of becoming malnourished. The corresponding care plans advise she is to be weight monitored every two weeks. Woodstock staff also attempted to incorporate MUST scores in to their care plans. However this was not well documented. The deputy manager explained that they experienced difficulty in obtaining height measurements for residents who were unable to stand for very long. "We haven't found a reliable system and have not been trained in MUST scoring".

On 22 January 2016, staff documented a MUST score of 0 for the resident in her care plan indicating low risk. This score is borne out by the discharge letter from MCH. However, the advice to carry out a monthly MUST screening is not followed due to the reasons stated by the deputy manager. We found that the person was weighed roughly every two weeks according to the care plan. Weights show a small but steady loss. 24 June 2016, weight was 63.5kg, a loss of 2.5kg since discharge from MCH. Woodstock's own eating and drinking care plan stated on 09 June 2016, "has lost weight - if she shows another weight loss we will re-refer to

dietician". On 24 June 2016 a further small weight loss is recorded, but there was no re-referral to the dietician. Further, this person's care plans did not contain a risk assessment for diabetes. We gave feedback to both the registered manager and deputy manager who confirmed that they do require further robust training in the use of the MUST screening tool. After our inspection visit, the registered manager sent us a new MUST screening tool they wish to implement and evidence that this person had been referred to the dietician. This demonstrated that the health related dietary needs of some people had not been met when we visited.

The example above demonstrates that the registered manager and staff failed to adequately implement healthcare professional's guidance in response to people's changing needs. This is a breach of Regulation 9 (1) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they encouraged people to eat and drink. One said, "If someone did not eat their food I would always go back and offer them something different." Another said, "People get plenty of food and they are offered snacks and at other times".

People and relatives were very positive about the quality of the food, choice and portions. One person said, "Delicious food, good cook here". One relative said, "The food always gets eaten. I have been able to join her for Xmas dinner and other times. Food plentiful and good". We observed lunch in the dining room where all the people were offered a choice. The food looked and smelt appetising and the portions were generous. Staff worked with the cook as team to ensure meals were delivered quickly and hot. Special requests and special dietary requirements were plated up separately. Other options were immediately available should anyone change their mind or want something not on the menu. The chef said, "if they do not like what is on the menu, we provide alternatives". We observed one person who refused the dessert offered (rice pudding) and said "I don't like that". Staff offered ice cream which they accepted. There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The chef was aware of the dietary requirements of people and she was very actively involved in the delivery of the food and service.

All staff completed training as part of their probationary period. New staff had provider's comprehensive induction records which they worked through during their probationary period. Staff told us that they were mentored by both deputy manager and the registered manager to help them to complete their induction. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the home. These skills were built upon with further experience gained from working in the home, and through further training. Staff told us that their training had been planned and that they could request further specialist training if needed.

People told us that the staff were knowledgeable and skilled and knew how to look after them.
One person said "I have been ill after I came out of hospital. I was very lucky the staff will do anything for you, so kind. Staff brilliant". Another person said "Staff are very confident, well trained. The girls are brilliant with everyone. They seem to go on training sessions" and "They don't employ anyone who hasn't done this work before. They are special people".

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living in the home. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. This allowed management to ensure that all staff were working to the expected standards, caring for people effectively, and for staff to understand their roles and deliver care effectively to people at the expected standard. Staff received refresher training in a variety of topics, which included health and safety,

fire safety, safeguarding and dementia awareness. Staff told us they were supported to attend relevant courses to maintain their skills and knowledge.

Staff were being supported through individual one to one supervision meetings and appraisals. This was to provide opportunities for staff to discuss their performance, development and training needs, which the registered manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. We were told that an annual appraisal was carried out with all staff. We saw records to confirm that supervision and annual appraisals had taken place. A member of staff also confirmed training needs were discussed as part of supervision and she could ask for training that would be of benefit to her in her role.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA) that included steps that staff should take to comply with legal requirements. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA and DoLS. One staff member explained that every person has some capacity to make choices. They gave us examples of how they supported people who did not verbally communicate to make choices. Staff were able to describe how capacity was tested and how a person's capacity impacted on decisions. They could all describe how and why capacity was assessed, the statutory principles underpinning the MCA and related this to people that we were subject to DoLS. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some of the people were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered 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.

Before people received any care or treatment they were asked for their consent. For example, we observed during medicine administration, staff gained the consent of each person, who was able to give consent, prior to administering their medicine. Staff interacted well with people, and asked them where they wanted to go and what they wanted to do. They obtained people's verbal consent to assist them with personal care such as helping them with their meals, or taking them to the toilet. Staff were aware of how to treat people with respect and that they allowed people to express their consent to different tasks. There were consent forms in place in each person's care plan. Consent forms had been appropriately completed by people's representatives where this was applicable. The forms showed the representative's relationship to the person concerned, and their authorisation to speak or sign forms on the person's behalf or in their best interests.

People or their representatives were involved in discussions about their health care. Relatives told us they are involved by staff in people's health care needs. One relative said, "If I want to know anything I just ask the staff. I have no worries about the care she is getting". One person said, "They took details of our medical needs before we came in. They try to keep us active. My wife likes the yoga and movement classes and this morning we played a game throwing a ball at a target".

The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the home regularly. A healthcare professional said, "Woodstock does normally contact the service CMHSOP Swale, which is Swale Community Mental Health Team for Older People or direct to myself to discuss any concern or issues of managing the client mental well-being. They do get the GP to refer to our service when they have concern in regard to their mental well-being".

Good

Is the service caring?

Our findings

People told us that staff were caring and treated them with respect. Comments from people included, "They treat me with respect. If I buzz they pop their head in and see if I am okay. If they are busy with someone else they will ask if I can wait for 5 minutes. They always remember, they will do anything for you". "Staff very respectful. Whatever I need they will do it for me". "Staff treats us with respect. If someone is being difficult they remain very patient with them and then gently take them out to their room".

Relatives told us that they found the staff caring and approachable. They commented "Staff are very caring, I have no problem speaking with staff. I cannot honestly say I can find fault with anyone or anything", "Staff are very caring, always there to see that the people are safe. Very reassuring for me", "Absolutely approachable, the staff are so good. She loves the carers, they are so tactical, quick kiss she just loves it. She loves all the young ones" and "Staff are very discreet and without any fuss they take them back to their room to change if there has been an accident"

We spent time and observed how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

People told us that staff always respected their privacy and did not disturb them if they did not want to be disturbed. We observed staff treating people with dignity and respect. Staff were attentive, showed compassion and interacted well with people. The environment was well-designed and supported people's privacy and dignity. All bedrooms doors were closed. People were able to personalise their bedrooms. Staff we spoke with during the inspection demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care for a person. We found the staff team was committed to delivering a service that had compassion and respect for people. Staff respected confidentiality. People's information was treated confidentially. People's individual care records were stored securely in lockable filing cabinets in the office, but could be accessed appropriately. We saw evidence that people were asked before information was shared.

We found that staff worked in a variety of ways to ensure people received support they needed. Equality and diversity was covered in people's care plans and it details people's preferences and individuality. For example one person likes to be called a certain name at certain times and other times, another name. We observed that staff called them these preferred names. Religious and cultural needs are also taken into consideration and in one person's care plan it said "Likes to attend Sunday or evening service when possible". This showed that staff supported people based on the person's choice and preference.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options,

such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

The staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

Staff knew the people they cared for well. They had good insight into people's interests and preferences and supported them to pursue these. The registered manager and staff that we spoke with showed genuine concern for people's wellbeing. It was evident from discussion that all staff knew people well, including their personal history, preferences, likes and dislikes and had used this knowledge to form very strong therapeutic relationships. This is a professional relationship between people who used the service and a staff based on ways of engaging with each other, and effect beneficial change in the person.

People were involved in their day to day care. People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed monthly by senior staff or whenever needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the home and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the home.

Good

Is the service responsive?

Our findings

One person said, "When I came out of hospital the staff helped me a lot. I just have to ask". Another said, "Staff very good. I like to do most things myself. If I need help I just have to ask".

Relatives told us that they were invited to their relatives care planning and knew when it was updated. One relative said, "It is always updated. I can see her care plan at any time. It is updated every month. Everything is clearly documented".

We asked healthcare professionals if people are supported to maintain good health, have access to healthcare services and receive ongoing healthcare and other support. A healthcare professional commented, 'Woodstock does use the service available to maintain the care of their client groups making contact to the GP for their physical health review and to CMHSOP Swale for any concern in regard to their Mental Well-being or in the Care Home Clinic run every four weekly to discuss and to implement intervention and to support the staff to manage the Client mental well-being'.

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. A person who experienced falls was provided with equipment that alerted staff when they stepped out of bed so they could provide help and reassurance. People were placed under observation following a fall and their progress was recorded. If needed they are referred to the 'falls clinic'. Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines administration following a G.P.'s visit and a review of their care. A healthcare professional commented, 'Care at Woodstock is fine and at reviews not many people have any issues around the care that they receive and families appear to be happy.' This showed that management and staff responded to people's changing needs whenever required.

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone and visits".

People were able to express their individuality. Staff acknowledged people by name as they walked past them in the lounges and corridors. People were responsive to staff and were eager to talk to them. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles

of furniture from their previous home, life history and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

Activities took place daily. The activities coordinator consulted people and took their preferences and suggestions in consideration before planning the activities programme. There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, identification of photographs and reminiscence, bowling, exercise, music, dancing, sparkle and arts and craft. One to one sessions included arms and hands massages, reading aloud and sing-along. The activities coordinator organised activities for each month. They said, "I involve people through meetings to discuss ideas with them. I do one to one sessions like quiz, chatting to them. This depends on people's interests".

There was a weekly activities timetable displayed on the notice board and people confirmed that activities were promoted regularly based on individual's wishes. Activities folder reviewed showed that activities were a regular feature in the lives of people living in the home. Activities completed with people included planting flowers, bingo, nail and hair care, supporting visitors to communicate with their relatives, large size jigsaw puzzles, cross words and word searches, and card making. The activities coordinator had word as a care worker previously for over eight years in the home. This meant that they knew people the supported well in order to engage with them.

The provider contacted other services that might be able to support them with meeting people's mental health needs. Details of Speech and Language Therapist (SALT) referral and guidance was in place demonstrating the provider promoting people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the home, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the home. The relatives feedback received for 2016 indicated that most people were satisfied with the service being provided. Feedbacks received from the questionnaires were used in developing the service further. For example, people wanted strawberries to be implemented in the summer menu. We found that this had been implemented in the menu by the registered manager. This demonstrated that the registered manager and staff listened to people who lived in the home.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). We found that there had been no complaints since our last visit.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. A relative told us, "If I had a complaint I would speak to the management time".

Good

Is the service well-led?

Our findings

Relatives told us that management team in the home are fine and they are happy to work with them. Comments included, "I think this is a pleasant home, nice and bright and clean. Happy with the care she receives. I don't think there are any changes needed. No complaints". "Everywhere is spotless. The vibe, the feeling and nose test tells us that this is well managed home", "Well organised home, food on time, lots of drinks and residents always looking well groomed" and "The staff always there for me, very nice people. Can say what I am feeling, they are very reassuring cannot speak highly enough of management".

Staff told us, "Management is very helpful, fair, and eager to listen to new ideas. I get on well with them", "Very helpful. Do receive supervision. Approachable" and "Management is very helpful and fulfilling. They have time for staff and residents. They are approachable. People here are safe. We meet their needs here".

The provider had a clear set of vision and values. These stated 'We believe every one of the individuals we support deserves dignity, choice and independence, as these values lay the foundations for a high quality of life'. Our observations showed us that these values had been successfully cascaded to the staff who worked in the home. Staff demonstrated these values by meeting people's needs based on their assessed needs.

The management team at Woodstock Dementia and Residential Care Home included the registered manager and the deputy manager. Support was provided to the registered manager by the provider representative, the operations manager. Both the registered manager and deputy manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us that the operation manager visited the home at least twice a month. This showed that the registered manager and staff were well supported by the provider.

We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the home. The registered manager told us they were well supported by the operations manager who provided all the resources necessary to ensure the effective operation of the service. The operations manager visited the home every month to carry out a monthly audit. The provider had effective systems in place for monitoring the home, which the registered manager implemented. They completed monthly audits of all aspects of the home, such as medicine, care plans, nutrition and learning and development for staff. They used these audits to review the home. Audits routinely identified areas they could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken. However, the care plan audit failed to identify the gaps we identified above. We discussed this with the registered manager who sent us their plan to rectify these gaps in order to ensure that the audits are more robust.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the home was facilitated through weekly and monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the home. Staff told us there was good communication between staff and the management team.

The home worked well with other agencies and services to make sure people received their care in a cohesive way. Healthcare professionals we contacted told us that the home always liaised with them. We asked healthcare professionals to tell us what the service does well. One healthcare professional said, 'I find Woodstock does acknowledge and to monitor their Clients well as they are aware of any physical or mental health concern'. This showed that the management worked in a joined up way with external agencies in order to ensure that people's needs were met.

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The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the home. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager and staff failed to adequately implement healthcare professional's guidance in response to people's changing needs.