Mr Dhanus Dharry Ramdharry, Mrs Sooba Devi Mootyen, Mr Dhanraz Danny Ramdharry

Woodlands Lodge Care Home

Inspection report

106 Hawshaw Lane
Hoyland
Barnsley
South Yorkshire
S74 0HH

Tel: 01226742977
Website: www.woodlandslodgecarehome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Woodlands Lodge Care Home took place on 7 and 12 February 2018 and was unannounced. This meant the registered provider did not know we were coming.

Woodlands Lodge Care Home is registered to provide accommodation and personal care for up to 55 people, some of whom are living with dementia. There were 48 people living at the home at the time of our inspection. The home is split into three different units; one of which is a locked unit, specialising in care for people living with dementia. Each unit has communal areas such as lounge and dining areas and one unit has a large sun-lounge.

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

The home had previously been inspected during January 2016 and was rated good in all of our five key questions at that time.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe living at Woodlands Lodge Care Home. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely and there were sufficient numbers of staff deployed to meet people's needs. Staff told us they felt supported and we saw evidence staff had received induction, training and ongoing supervision. The registered manager had identified improved methods of training were required and was working towards implementing these.

Risks to people had been assessed and measures were in place to reduce risks. However, the quality of risk assessments was variable. Some moving and handling plans lacked detail to provide staff with sufficient information for staff to safely assist people to move. The registered manager had already identified this and work was continuing to improve these.

The building was well maintained and regular safety checks took place. The environment, particularly for people living with dementia, had recently improved.

Staff responded appropriately to emergency situations. Accidents and incidents were analysed and lessons

were learned and shared.

Medicines were managed, stored and administered safely and appropriately, by staff who had been trained, and assessed as competent, to do so.

Our observations showed people were supported to have choice and control of their lives and we observed staff supported people in the least restrictive way possible. However, the principles of the Mental Capacity Act had not been followed. We identified a breach of regulation in this area.

People received appropriate support in order to have their nutritional and hydration needs met.

People told us staff were caring and we observed staff to be kind and considerate. We observed people's privacy and dignity was respected. People were encouraged to maintain links with their family and community. People's diverse needs were considered.

The quality of care records was variable and we found the registered manager was working to improve these. People told us they could make their own choices in relation to their daily lives.

There was a complaints policy in place and we found the registered manager had responded to complaints appropriately and in line with policy.

Staff told us they felt supported and people and their relatives spoke positively about the registered manager. Meetings such as staff meetings and residents' and relatives' meetings were held regularly. Regular audits and quality assurance checks took place, to help improvements to continue at the home.

We found a breach of regulation in relation to Consent. You can see what action we told the provider to take at the back of the full version of the 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.

People told us they felt safe.

Risk assessments and people's moving and handling plans did not always contain sufficient information to ensure staff could assist people safely but the registered manager had already identified this and was improving these.

Staff were recruited safely and sufficient numbers of staff were deployed to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 were not always followed.

Staff had received induction, training and ongoing support to enable them to provide effective care and support to people.

People's nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were caring and our observations confirmed this.

Staff were skilled at communicating with people and we observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The content of care records was variable, with some containing personalised information reflecting individual needs and others did not. Work was ongoing to improve this.

Records did not indicate people had been involved in reviewing and developing their care plans.

Complaints were managed well, in line with policy.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Regular audits and quality checks took place which resulted in continued improvements in the home, but further work was required in order for the registered provider to be fully compliant with regulations.

There was a registered manager in post and they had begun to drive improvements at the home. People and staff told us they had confidence in the registered manager.

The registered provider had up to date policies and procedures in place.

Woodlands Lodge 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 was 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 took place on 7 and 12 February 2018 and was unannounced. The inspection was carried out by an adult social care inspector and an expert by experience on the first day and an adult social care inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home and we gathered information from local stakeholders, such as the local authority and service commissioners. The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan and inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We used the Short Observational Framework for Inspection (SOFI) to observe one of the dining areas. SOFI is a way of observing care to help us understand the experience of people who could not communicate verbally with us.

We spoke with seven people who lived at the home, six relatives of people who lived at the home, one visiting healthcare professional, four care and support staff, the activities coordinator, a housekeeper, the deputy manager and the registered manager. We also approached another six care workers to let them know we were available so they could speak with us if they wished to do so.

We looked at six people's care records, four staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Woodlands Lodge Care Home. One person told us, "It's like home from home and I'm much safer here than at home, which makes my family happy." Another person told us, "I feel safe and well cared for." A family member told us, "I'm happy with my [relative]'s care. I can go home knowing they are safe and happy." We spoke with a visiting healthcare professional during our inspection and they told us they had, "No concerns whatsoever," about the home.

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. Records showed safeguarding incidents had been appropriately reported and had been investigated by the registered manager. We were told by the registered manager people were protected from discrimination because staff received equality and diversity training and people were treated equally, whilst taking into account their individual needs and characteristics. Records showed the registered manager had recently reminded staff of the safeguarding and whistle blowing policies and staff indicated to us they understood these. This showed staff would take appropriate action if they had concerns anyone was at risk of abuse or harm.

Risk assessments had been undertaken for a range of risks, such as those associated with falls, diet and nutrition and skin integrity. Some recognised risk assessment tools were used to help determine risks. However, the quality of risk assessments was variable. For example, one person's risk assessment identified they were at high risk of falling if left unsupervised in their wheelchair. However, the assessment did not outline the measures in place to reduce the risk.

Some mobility care plans were not sufficiently detailed to enable staff to follow these, in order to provide safe, effective support to people in terms of their mobility. For example, the plan for a person who required assistance from two members of staff, using a hoist, did not detail the type of sling to use or outline the method of application when using equipment. Whilst we did not observe any unsafe moving and handling of people, this meant appropriate plans were not always in place to ensure staff knew how to assist people to move safely. The registered manager confirmed, and records showed, they had already identified through their auditing that some risk assessments and moving and handling plans were not sufficiently robust and some were lacking and it was clear the registered manager was already working to improve these.

Regular safety checks took place throughout the home. Records showed fire alarms, emergency lights and firefighting equipment were checked regularly. Tests such as gas and electrical safety and portable appliances had been completed. Lifting equipment had been tested as safe to use. This helped to ensure the safety of premises and equipment.

During our inspection, the emergency services were called to a person. Staff had taken appropriate action, kept the person warm and comfortable and protected the person's dignity until the emergency services arrived. Staff then shared relevant information with the paramedics. Records showed, in relation to other accidents or incidents, appropriate actions had been taken such as first aid and subsequent increased

observations. This showed staff knew what to do in an emergency.

The registered manager told us lessons were learned both at a local and national level, either from incidents within the home or incidents nationally and the registered provider would share learning with the registered manager. Records showed analysis took place of accidents and incidents. This took into account details of when and where any accidents or incidents occurred as well as other factors. This enabled the registered manager to learn lessons and to identify any trends in accidents and incidents. Records showed this analysis was effective and referrals were made to other healthcare professionals, where appropriate, as a result.

The registered manager told us they felt there were sufficient numbers of staff deployed to keep people safe. They used a dependency tool to assist them in determining staffing levels and, according to the tool, they were slightly overstaffed by a number of hours. Records showed the dependency tool considered people's needs in relation to different areas of care such as eating and drinking, continence, communication, mobilising and tissue viability. A healthcare professional we asked told us, "I never have to go looking for staff. There seems to be enough." All of the staff we asked said they felt there were sufficient staffing levels to keep people safe, although some commented person centred care would be improved if the numbers of staff were increased.

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

We looked at how medicines were managed. Medicines were administered by staff who had received specific training in this area. Furthermore, since coming into post, the registered manager had assessed the competency of staff administering medicines. Medicines were administered in a kindly manner and we observed the member of staff administering medicines stayed with each person until they had taken all of their medicines.

Medication administration records (MARs) included a photograph of the person, which helped to ensure medicines were administered to the correct person.

Where MARs had been hand-written, such as when a person was newly admitted to the home, these were counter-signed by another staff member. This was good practice in line with the National Institute for Health and Care Excellence (NICE) guidelines, and reduced the risk of errors in transcribing medicines information.

Most medicines were supplied in monitored dosage systems with a printed MAR. The member of staff administering the medicines ensured they were popped into a medicine pot without touching the medicine. This helped to ensure good infection prevention and control practice.

Some people were prescribed medicines to be taken as and when required, known as PRN medicines. PRN protocols were in place which helped to ensure these medicines were administered appropriately and at safe intervals. We checked a random sample of these medicines and records showed the amount of medicines remaining reconciled with the records.

Medicines were stored securely in trollies in a locked room. Temperature checks regularly took place to ensure medicines were being stored at correct temperatures. Dates of opening were written on items which had an expiry date after opening, such as eye drops. These measures helped to ensure medicines were managed and stored safely.

We checked the controlled drugs, which are prescription medicines controlled under Misuse of Drugs legislation. These were stored securely and logged in the register as required. This showed controlled drugs were managed appropriately.

Records showed the registered manager had addressed with staff the need for ensuring people were encouraged to wash their hands before and after meals and to encourage people to use hand wipes where this was refused. We observed this in practice during our inspection and people were encouraged to clean their hands before and after their meals. This showed good personal hygiene was being promoted.

We observed staff wearing personal protective equipment (PPE) at appropriate times during our inspection and staff told us they had adequate supplies and access to PPE. We observed cleaning taking place throughout the inspection and areas looked visibly clean. Although there were some malodours at times within the home, these cleared throughout the day, as cleaning took place.

We noted some slings were stored draped over hoists and the same slings were used for multiple people during moving and handling. We asked a staff member about this and they told us, when they were assisting people to move, they selected appropriate slings based on their size but confirmed the slings were not individual to people. It is good infection prevention and control practice to use individual slings for people because shared slings increase the risk of the spread of infection. We raised this with the registered manager who agreed to take action.

Requires Improvement

Is the service effective?

Our findings

People were confident staff had the necessary skills to provide effective care. One person told us, "They [staff] do know what they're doing." A healthcare professional told us, "They [staff] are good at following our advice. Staff are knowledgeable and, yes, they seem to have had sufficient training. The seniors [senior care workers] are very good."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

We checked whether the service was working within the principles of the MCA. When we discussed the MCA and associated DoLS with the registered manager, they were aware of the principles and requirements of the Act. However, these had not been applied in practice at the home. We were not able to establish which people living at the home lacked capacity to consent to their care and treatment. There were no decision specific mental capacity assessments in all of the care records we reviewed, yet some people did lack capacity to make some decisions.

The registered manager's action plan showed the lack of mental capacity assessments had been identified and this had been raised with senior carers. However, at the time of this inspection, records showed the mental capacity assessments had not taken place.

Records did not accurately show whether DoLS applications had been made, or had been authorised, for people living at the home, including those people residing on the unit which was secure and specifically designed for people living with dementia. This meant some people, who lacked capacity, were being deprived of their liberty without authorisation. We recommended the registered manager undertake an audit specifically in relation to this and take appropriate action. They agreed they would further consider this.

The above demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because staff did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

Formal consent was not consistently obtained. For example, one care record we sampled stated, 'I have informed staff I would like bed rails on my bed. I have capacity to make this decision.' This showed the person had consented to bed rails. However, in another record we inspected, we saw a consent form

relating to bedrails, use of photographs and access to care records and none of the sections had been completed. This meant records of consent were inconsistent.

Throughout our inspection, we observed staff asked for consent prior to providing care and support to people. Staff could be heard asking people, "Can I move your wheelchair to here?" and "Can I put your plate there?" and "Would you like some help?" This showed staff sought consent from people in practice.
Staff received an induction prior to commencing their caring duties, which included shadowing more experienced members of care staff. Although the registered provider did not enrol staff on the Care Certificate, their induction was aligned to the subject areas of the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

The training matrix showed staff had received training in areas such as safeguarding, health and safety, moving and handling, dementia awareness, fire safety and first aid. The registered manager had identified staff had previously lacked effective training, because most of this was completed on-line. A system had been devised to record and monitor staff training. The registered manager told us, and records showed, they were in the process of sourcing more effective training for staff, through the local authority. The registered manager had shared this information with staff and was reminding staff of the importance to take the action required, in order to be able to be enrolled on this training. This showed the registered manager was being proactive and taking steps to improving staff training.

Additionally, records showed the registered manager had invited staff to become champions in specific areas of interest, such as dementia care and dignity. The staff we asked told us they would feel able to ask for additional training if they felt this was required, or if they were not confident in a particular area of care. They told us they felt this would be provided.

Records showed the registered manager had introduced a system to ensure staff received regular, formal, one to one supervision. We saw staff were praised for their good work and any shortfalls in practice were addressed. Staff were reminded of the importance of specific areas of providing effective care and the recording of information. Records showed discussions also took place in relation to individual staff training and development. This showed staff received support and supervision in their roles.

We looked at how people's nutritional and hydration needs were met. We observed water dispensers and cups were available in communal areas so people could stay hydrated. We looked at the records for a person who had lost weight. The person had been regularly weighed and a consultation with a dietician had been arranged. This showed action was taken where people were identified at risk of malnutrition.

We observed two meal-time experiences. At meal-times, tables were set for dining with table cloths, cutlery and condiments. Choices of hot or cold drinks were offered. Easy listening music was played in the background and there was pleasant conversation and atmosphere.

Staff discreetly asked people if they wanted to wear aprons to protect their clothes and people's choices were respected. A member of staff asked a person if they would like assistance to cut up their food. The person declined and the staff member said, "Okay, but just let me know if you want some help." This showed staff were respectful of people's independence whilst offering support to people to eat their meals.

Staff could be heard saying, "Have you had enough?" and "Have you enjoyed it?" before taking plates away at the end of the meal. People were complimentary about the food.

On one unit we observed a person, who was living with dementia, was continually attempting to stand and leave the table whilst a member of staff was assisting them to eat their meal. The member of staff patiently and effectively encouraged the person to stay at the table and eat their meal. As a result of this effective care, the person chose to remain at the table and finished their meal.

We looked at the design and layout of the home. There were homely pictures and quotes on walls and flowers displayed within the home. The unit which was specifically designed for people living with dementia had contrasting colours, for example on hand rails and toilet seats, which helped people to navigate and identify items more easily. Items of interest were placed around the home, such as a pram, dolls, pictures, magazines and books. A member of staff told us, "The EMI [dementia] unit has changed for the better. It's made it a lot easier for the residents. It's easier for people to find their own rooms. They love the dolls, teddies, different textures. It gives people comfort. [Registered manager] has made it so much better."

Handovers between each shift took place. Appropriate information was shared which enabled staff to provide continuity of care when care staff changed.

Records showed people accessed a range of health care professionals, such as opticians, chiropodists, district nurses and GPs. People told us staff acted promptly if they required access to healthcare professionals. This showed people received additional support to meet their health care needs.

Good

Is the service caring?

Our findings

People told us staff were caring. One person told us, "Staff are great and friendly." Another person said, "It's nice in here." Family members also told us staff were very caring.

During our observations we found staff to be caring in their nature. We observed a member of staff assisting a person to eat their porridge. The staff member had a gentle manner and sat quietly, talking to the person and remained engaged throughout. One member of staff told us, "I love my job."

The registered manager had shared some best practice with staff, through a weekly memo, regarding effective ways to communicate with people who had Alzheimer's. We observed staff communicating positively with people, and staff demonstrated they understood how to communicate well with people.

The staff we observed on the dementia unit provided effective care and were patient with people who were, at times, displaying repetitive behaviour and which some people may find challenging. Staff created a calm atmosphere and people responded well to this.

The registered provider had a recently developed 'diversity in care' policy. This outlined the registered provider was fully committed to the principles of equality and stated that all people would be treated equally, regardless of their characteristics such as age, disability, gender reassignment, race, religion or sexual orientation. This showed the registered provider was aware of their duty to ensure people were treated equally. All of the staff we asked indicated a commitment to providing an inclusive environment for everyone. A member of staff told us, "I treat people how I would like to be treated."

There were links with a local church and a religious leader regularly visited the home to deliver a service to those who wanted to take part. During our inspection a religious leader came to provide a service. This showed people were able to maintain links with their community and practice their chosen faith.

The registered manager had requested and encouraged some staff to become dignity champions, although this was not yet embedded. We saw a 'dignity wall' had been created and the registered manager had encouraged staff to look at this and 'Show our residents what we want to achieve'. This showed the registered manager was keen to ensure staff were promoting dignity.

Staff explained to us the actions they took to ensure people's privacy and dignity were maintained. One member of staff said, "I make sure I close curtains and doors if I'm helping someone with personal care. I use a towel to keep the person covered as much as possible. I wouldn't want anyone feeling uncomfortable." We observed staff respecting people's privacy and promoting dignity throughout our inspection.

Where people needed assistance from staff, this was provided in a caring, respectful manner. For example, when a staff member was assisting a person to eat their meal, we could hear the staff member engaged in soft conversation and they reminded the person what they were eating.

One person's care plan stated, 'I am able to eat independently some of the time but there are times I struggle to maintain my independence. On days I am struggling I like staff to prompt me.' This showed consideration was given to the importance of retaining independence at the care planning stage. We observed staff encouraged people to retain their independence throughout our inspection.

The registered manager told us, and records showed, access to advocacy was arranged where necessary. An advocate is a person who is able to speak on another person's behalf when they may not be able to do so, or may need assistance in doing so, for themselves.

Requires Improvement

Is the service responsive?

Our findings

People told us they could make their own choices. One person told us, "I get up when I want to. I like to get up early and that's okay."

Care plans contained a photograph of the person to whom they related. Care records included details of the support people required, in relation to different aspects of care such as eating and drinking, personal care, communication, mobility, social interaction and skin care.

Information relating to some people's preferences was included in care plans, for example in relation to whether people wished to have keys to their own room and whether they preferred to have their doors locked or unlocked. Some people's needs had been considered in terms of their religion and whether they were 'practising'. Some care plans contained information relating to people's preferred routines and food and drink preferences. One of the care plans we reviewed contained detailed information relating to a person's family history.

However, some other care records we looked at lacked personalised information. For example, some care plans contained a section which was meant to capture life history details. However, we found not all care plans contained this information.

Although some care records contained information relating to people's choices and preferences, this was not consistent and care records did not indicate people had been enabled to be continually involved in developing and reviewing their care. The registered manager told us they were continuing to work on improving care plans and this was evident in their action planning.

A range of activities were on offer at the home. People responded well to the activities coordinator, who engaged positively with people. We overhead conversations people were having in relation to recent activities they had engaged in and people spoke with enthusiasm about these.

A member of staff told us, "There are loads of activities here. People join in. We do board games, singing, dancing, music. Today we've been doing exercises." During our inspection, exercises had taken place and an external visitor had brought a 'dementia dog' into the home. People engaged enthusiastically with the dog and the dog's handler and this had a positive effect on people, evident through people smiling and laughing and sharing affection for the dog. Dementia dogs are specially trained to show empathy to those around them.

We were told family members could visit the home any time and we observed some family members attended at meal-times on a regular basis. However, they were not able to sit with their relatives to eat their meal. We were told this was because there was no space in the dining area for family members to sit with their relatives. When we raised this with the registered manager, they agreed to give further consideration to how family members could eat meals with their relatives, including purchasing an additional dining table.

People's rooms were personalised and we saw photographs and items of sentimental value were displayed. Staff told us, and people confirmed they could make their own choices such as when to rise in a morning or when to retire to bed on an evening. People told us they could choose when they wished to bathe or shower. This demonstrated personalised care was provided.

We looked at how information was provided and shared with people. The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand and any communication support they need. Although the registered manager was not aware of the Accessible Information Standard, we saw information had been provided in alternative formats. For example, some information was pictorial and we saw care records contained information relating to people's specific communication needs. This showed consideration was given to people's individual needs in relation to communication methods.

Records showed the registered manager had met with relatives and encouraged them to share any concerns they had. Details of how to complain had been shared. A family member told us there had been some concerns regarding how laundry was managed. Records showed the registered manager had raised this during a meeting and had asked families to label people's clothing to try to resolve this.

When the registered manager came into post in September 2017 they identified a previous complaint had not been appropriately investigated and responded to. They therefore contacted the complainant to apologise and then investigated the complaint and took actions to resolve the issue. Records showed, since the registered manager had been in post, complaints were responded to and investigated appropriately, in line with policy.

Care records contained a section to record end of life wishes. However, the registered manager acknowledged further work was required in this area to capture people's wishes. The registered manager was mindful of the importance of understanding people's choices in relation to end of life care whilst having sensitive, respectful conversations. The staff we spoke with understood, and were able to outline, what good end of life care looked like.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had begun working at the home in September 2017 and had been registered with the Care Quality Commission (CQC) to manage the home since January 2018.

All of the people living at the home, their relatives and staff gave positive comments about the registered manager and about how the home was improving. One staff member told us (in relation to the new registered manager and the changes being implemented), "It doesn't suit all staff because some don't like change, but it's definitely improving and I think staff can see that now." Another staff member said, "The changes have really frustrated us, but it's for the better." A further staff member told us, "I think it's loads better. She's [the registered manager] trying to better the home. Who wouldn't want that?" Regarding the registered manager, another member of staff told us, "I think she's doing a fantastic job. It's mind-blowing to think how much we're improving."

People living at the home and their relatives felt they would be listened to and had confidence in the new registered manager. A family member we spoke with told us the home had, "Significantly improved," since the new manager came into post.

The registered manager told us they felt supported in their role and they communicated with the registered provider almost daily. They engaged in local forums, which provided peer support and attended meetings with the local authority which enabled them to learn and share good practice.

Records showed weekly memos were issued to staff by the registered manager. These contained inspiring quotes and communicated positive messages to staff and thanked staff for their hard work. These memos showed staff were asked for their ideas and feedback and encouraged to speak with the registered manager if they had any concerns, indicating 'It doesn't matter how little.'

We observed the registered manager knew people and interacted with people throughout the inspection, in a respectful manner.

Since coming into post, the registered manager had held meetings with staff, relatives and people living at the home. A staff member told us, "We can give our opinions at the meetings." Meetings are an important part of a registered manager's responsibility to ensure information is passed on to staff appropriately and to come to informed views about the service.

People had been involved in decisions relating to the home. For example, records showed the registered manager had met with people and asked for their views about the seating arrangements. Records showed the registered manager shared information with relatives regarding the role of the CQC and advised families they could contact the CQC if they had concerns about the home.

Questionnaires had been sent to staff and the results had been shared with staff during January 2018. Staff had been asked for their ideas in relation to improvements at the home. Resident satisfaction surveys had

been completed by 21 people living at the home in October 2017. Issues raised, such as laundry management, were addressed and actions were taken to improve the quality of service provision. This showed the registered manager was seeking and acting on feedback from people who used the service.

We sampled seven visitor questionnaires from October 2017. These all rated 'quality of care' as good or excellent. 'Friendliness of staff' was rated as excellent by all respondents and 'cleanliness of the home' was rated as good or excellent in all questionnaires returned.

Since coming into post, the registered manager had undertaken thorough audits and had devised an action plan, which showed actions required, who would be responsible and the timescale for completion. Some of the actions had been completed and some, with a longer timescale, were ongoing at the time of our inspection. This showed the registered manager was aware of the improvements required and was working towards these.

Regular medication audits took place and these resulted in actions being taken to improve the management of medicines. Actions were clearly outlined with details regarding who was responsible for taking action and the timescale for doing so. Other audits took place regularly, for example in relation to the environment, mattresses, pillows, pressure cushions. The audits were effective at improving the level of care provision at the home.

Records showed the registered provider visited the home regularly and spoke with people and staff to gather feedback. Quality audits took place in relation to the environment and actions were taken where these were identified as required.

The registered manager undertook regular quality assurance observations of staff practice. Feedback from these observations were fed back to staff members and this helped to improve their practice. Mealtime observations had also taken place. Feedback was provided to staff and this resulted in improved practice. A member of staff told us, "I got feedback on my performance and it was positive. It's good to know I'm doing it right."

The registered manager had developed an emergency contingency plan. This meant plans were in place in the event of different emergency situations such as flood, severe weather and utilities failure.

The registered provider worked in partnership with the local college. At the time of our inspection there were three students, who were studying health and social care, being supervised on placement at the home. This demonstrated the registered provider had links with other local organisations.

Records showed the home was planning to take part in the National Care Homes Open Day which was planned to take place during April 2018. The local Mayor had confirmed attendance at the home for this event. A tea party was being planned for the event to celebrate the Queen's birthday. This further demonstrated links with the local community.

The registered provider had a range of up to date policies in place such as in relation to the administration of medicines, fire safety, safeguarding and whistleblowing. Having up to date policies helps to ensure staff are following current, up to date guidelines.

The previous inspection ratings were displayed. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

It was clear the registered manager was effective in their role and, as a result, they were driving improvements at the home. However the breach of regulation, referred to in the key question of effective, meant the home required improvement in order to attain a 'good' rating in the key question of well-led.

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 11 HSCA RA Regulations 2014 Need for consent Staff did not act in accordance with the requirements of the Mental Capacity Act 2005.