A R Omar

Whyke Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 9 and 11 August 2016 and was an unannounced inspection.

Whyke Lodge Care Home provides care and support for up to 23 older residents, all of whom have cognitive impairments such as Alzheimer's, dementia and memory loss. At the time of our visit there were 20 people living at the home.

The service has a registered manager. 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, relatives, staff and professionals spoke highly of the home and had confidence in the care provided. We found that Whyke Lodge Care Home was providing a high standard of care to people.

People had good relationships with the staff who supported them. Staff took time to get to know people and to understand their needs and wishes. Staff spent time with people on an individual basis and offered support in a way that upheld their privacy and dignity.

Staff were skilled in supporting people living with dementia. There were enough staff on duty to support people safely and to ensure that their needs were met. The staffing numbers provided flexibility to offer one to one support to people if they were feeling anxious, to help people participate in activities and to support them if they wished to go out in the community. Staff had received training and were supported by the management through supervision and appraisal. Staff were able to pursue additional training which helped them to improve the care they provided to people.

People and their representatives were actively involved in planning and reviewing their care. Staff took time to understand people's interests and wishes so that they could tailor their support. We observed that people received sensitive, caring and prompt support from staff. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were proactive in monitoring people's health and in anticipating changes in their needs. This meant that additional support or equipment could be arranged in good time. Staff took note of people's wishes and advocated on their behalf if they felt changes in their care were needed.

People felt safe at the service. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse.
Risks to people's safety were assessed and reviewed. People received their medicines safely.

People enjoyed home-cooked food and were able to make suggestions for dishes they would enjoy. Staff were attentive and supported those who required assistance to eat or drink. People's weight was monitored and prompt action taken if any concerns were identified.

People were supported to participate in activities that interested them. There was a full activity programme on offer at the home which people told us they enjoyed. People who were not able to join in group activities were supported on a one to one basis by staff.

There was strong leadership within the home. The registered manager and deputy monitored the delivery of care and had a system to monitor and review the quality of the service. Suggestions on improvements to the service were welcomed and people's feedback encouraged.

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 said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were enough staff to meet people's needs and keep them safe.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal. Staff understood how to engage with and support people living with dementia.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet. Staff took prompt action to address any unplanned weight loss and to encourage people to eat.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received individualised care from staff who cared and who knew them well.

People were involved in making decisions relating to their care

and were supported to maintain contact with family and friends.

People were treated with dignity and respect.

People were supported at the end of their lives to have a comfortable and dignified death.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their needs. Staff were proactive in monitoring people's health and anticipating changes in their support needs.

People were enthusiastic about the activity programme and engaged in making suggestions for future events.

People were asked for their views and were assured of a swift response to any concerns.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager and leadership team. Staff were clear on their responsibilities and told us they were listened to and valued.

The registered manager used a series of audits to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

Whyke 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 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 9 and 11 August 2016 and was unannounced.

One inspector and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed two previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We looked at care records for five people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at four staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits, minutes of meetings, newsletters and the service user guide.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During our inspection, we met and spoke with 14 people using the service. We were able to have detailed conversations with three people about their experiences of the care at Whyke Lodge Care Home. We met with the relatives of four people. We spoke with the registered manager, the deputy manager, one team leader, three care assistants, the chef and a representative of the provider. Following the inspection, we contacted a clinical nurse lead, a Community Psychiatric Nurse (CPN), a GP and a dentist. They consented to share their views in this report. We received additional written feedback from a specialist nurse practitioner with responsibility for dementia reviews.

Whyke Lodge Care Home was last inspected in January 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe at the home. One person told us about their partner who also lived at the home. They said, "They talk to me about her. She can't talk herself. They know what to do, I don't have to worry". We observed that people appeared relaxed in the company of staff. Relatives had confidence in the care provided. One said, "I know she is safe and they will make sure she comes to no harm". Another had written to thank the staff saying, 'Thank you so much for the high level of care you and your team provided to (name of person). I know she felt very safe at Whyke Lodge and she was always treated with compassion and respect'. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Staff told us that they felt able to approach senior staff or the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team.

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, pressure areas or from social isolation, these had been assessed. Risk assessments detailed what reasonable measures and steps should be taken to minimise the risk to the person. For example, we observed that some people were wearing protectors to reduce the risk of them injuring themselves as they had fragile skin and were at risk of bruising or skin tears. Staff applied prescribed creams to help protect people's skin and carried out regular checks to spot any changes. The clinical nurse lead told us that staff were good at minimising the risk of pressure damage. She said, "They give a really high standard of care. They will go to the end to try and protect the skin. If there is any hint of an area getting a bit pink they are in contact".

There was detail for staff on how to adapt their support to respond to changes in people's mobility or wellbeing. For example, we read that one person had a wheelchair for use if their mobility was poor and another required the support of two staff to transfer if they were feeling anxious. We observed staff supporting people to move safely around the home, including using hoists to help people transfer. When people were known to present with behaviours that might challenge, there was detailed written guidance for staff on how to reassure the person and on methods that had proven effective in calming them. One relative told us, "In the other home (name of person) was at risk of hurting herself and they couldn't control her behaviour, here they do and she is calm and okay". We found risks were managed safely for people.

The registered manager ensured that equipment was checked regularly to ensure it was functioning correctly and safe to use. Staff carried out monthly checks on the wheelchairs and frames that people used. There was a procedure in place to deal with any emergencies, including a contingency plan should the home be uninhabitable due to an unforeseen emergency such as a fire or flood. Each person had a personal evacuation plan which detailed how they would safely leave the premises and what support would be required.

There were enough staff on duty to support people and keep them safe. One person told us, "I always get

help if I need it. I don't need much, I just need them to talk to and get my meals". Another said, "I get up at night and they are always there". Staff told us that they were able to spend time with people and support them with activities. One staff member said, "I feel free. I can talk to the residents and walk with them". We observed that staff had time to support people and engage with them. When one person appeared anxious, staff supported them. This person received one to one support over lunchtime and in the afternoon. Staff supported them to eat their meal, spoke reassuringly to them and walked with them in the home. Staff told us that this was possible within the staffing numbers.

The registered manager considered the support needs of people using the service to determine the staffing numbers. At the time of our inspection, the staffing hours provided were greater than the hours of care shown in the registered manager's dependency review. During the week, the deputy manager and registered manager were available to provide support to people. At weekends, there were more staff on shift to ensure that there was adequate cover. At lunchtime, there was an overlap of staff working on the morning and afternoon shifts to ensure that there were sufficient staff to provide assistance to people in eating their meals. When activities were planned, additional staff were on shift to facilitate this. We found that the staffing level provided flexibility and enabled staff to support people in a person-centred way that met their needs.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history, on their eligibility to work in the UK and with the Disclosure and Barring Service (DBS). The DBS provides criminal record checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk. At the time of our inspection, there were no vacancies in the staff team.

People received their medicines safely. Staff who administered medicines had received training and their competency had been assessed before they worked independently. There were recorded details of how each person liked to receive their medicines. Each person's medicines were prepared and taken to them, before staff returned to update the Medicines Administration Records (MAR). The MAR demonstrated that people had received their medicines as prescribed. Where medicines were prescribed on an 'as needed' (PRN) basis, there was guidance to describe the dose and the expected effect. Each time the medicine was given, staff recorded the time and the reason for administration. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. Storage arrangements for medicines were secure. Medicines that needed to be kept cool were stored in a fridge and the temperature was recorded daily.

Good

Is the service effective?

Our findings

People spoke highly of the staff and had confidence in their skills. One person told us, "I get what I need. They take care of me. I get all the things I need done for me". Staff were happy with the training they received. They told us that additional courses were available. One care assistant said, "I keep learning".

The provider had a training plan which detailed the courses staff in a particular role would be expected to complete. For care assistants this included, understanding dementia, health and safety, safeguarding, moving and handling, fire safety, diversity and inclusion, principles of person-centred care, food hygiene and effective communication. Staff had also received training in infection control and in the Mental Capacity Act 2005 (MCA). The registered manager maintained a clear record of when staff had attended training. We found that staff training included key topics relevant to the care of people living at Whyke Lodge Care Home and that staff had attended refresher training to keep their knowledge up to date.

Staff demonstrated skill in supporting people living with dementia. They used a variety of communication methods, including touch and gesture to engage with people. People appeared pleased to see the staff and welcomed their company. During the morning's musical activity, staff sat with people and supported them to participate. We observed that as staff joined people, held their hands and talked quietly to them, they became more alert and appeared to enjoy the activity. Staff were perceptive to people's moods and wishes. When one person appeared ill at ease, staff quickly assisted them to leave the room. In the afternoon, when staff offered one person a cup of tea, they responded, "I haven't got any change with me; can you put it on my bill?" The staff member replied cheerily that they could. The deputy manager told us, "All the staff here are trained and experienced. We understand people and different behaviours. We keep it calm. Staff allow people space but step in if need be".

Staff were encouraged to pursue further training. Additional courses in topics such as stroke, challenging behaviour, diabetes awareness, epilepsy, promoting continence and pressure ulcer prevention had completed by some staff. Others had completed certificates in the principles of dementia care and the management of diabetes. Further training had been arranged to help staff understand the needs of people they were supporting, for example there had been a talk from the Parkinson's society. The deputy manager told us, "If we have a service user with a condition we can only teach so much so we try to get professionals to come in and update". When updates or new best practice guidance was identified, this was shared with staff and they were required to sign to say they had read it. Recent information included guidance on eating well with dementia, the MCA and to watch a film that depicted the experience of one person and their family as they learned of a diagnosis of early onset Alzheimer's.

New staff completed a period of induction, which included the shadowing of senior staff. This period of shadowing could last for up to three months, meaning that the new staff member was supernumerary on the rota. During this period, a checklist was used to ensure that key areas were discussed and explained. All new recruits were expected to complete the Care Certificate, which is a nationally recognised qualification. The registered manager explained that they tailored the information to make it specific to the needs of the people they supported, for example by providing detail on communication methods that people used. The

deputy manager told us, "We can tell if they'll be a good carer, if they are understanding".

Staff felt supported. One care assistant said, "I tell the management if I am struggling. They support me". A clinical nurse lead told us, "(Deputy manager) will stay on as long as needed. She'll never leave her team unsupported". Supervisions were arranged for staff to discuss their performance, any training needs and their ideas on how to improve the service. There was also a system of observations to monitor staff performance. This included how they supported people to wash, dress and transfer using a hoist. Each year, staff attended an appraisal which considered their achievements and looked ahead to the coming year. At the time of this inspection, all but three staff had attended their 2016 appraisal.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, staff had made applications on behalf of people who were considered to be deprived of their liberty. One application had been authorised and the remainder were awaiting assessment by the local authority team.

We checked whether the service was working within the principles of the MCA. We observed staff involving people in day to day decisions, offering assistance and waiting for people to respond to questions. One person told us, "I can do what I want. I don't have to stay here. I talk to the staff. I know I need to be here, but they don't make me, they just talk to me about it. I don't worry about things because they are always here to talk to". We saw that people had refused support on occasions and that this had been respected. A specialist nurse practitioner told us, 'Personal needs and medical needs are well addressed with awareness for the individual's capacity and best interest'.

Staff understood the requirements of the MCA and put this into practice. People had been asked to consent to decisions relating to their treatment. Where they lacked capacity to understand the decision, staff had involved the person's relatives and relevant healthcare professionals to make a best interest decision on their behalf. A recent best interest decision had been made not to admit one person to hospital. This had involved the family, GP, admissions avoidance nurse and staff at the home. Clear guidance was in place to describe how staff should support the person and who they should contact if they were unwell or in pain. A relative told us how the home and GP had involved them in a best interest decision regarding further tests in hospital. They told us that they were given enough information to make an informed choice. Where people had appointed representatives to act on their behalf, staff had a record of this. The registered manager was in the process of obtaining copies of these authorisations so that they had confirmation that the representative was authorised to make decisions on behalf of the person.

Staff had assessed people's capacity and recorded best interest decisions in relation to daily care decisions. This included decisions around nutrition and continence. We noted that where equipment was in use to minimise the risk of falls, there was no capacity assessment or best interest decision on file. One person used bed rails and another used a sensor mat to alert staff when they got up during the night. The deputy manager told us that these decisions had been discussed with the relatives and made in conjunction with the district nurses. The deputy manager and representative of the provider told us that they would update the records to demonstrate that the decisions had been made in line with the MCA and that people's rights

had been protected.

People appeared to enjoy their meals. When people moved to the home they were asked for their food preferences and these were recorded along with any specific dietary needs or allergies. One person told us, "The diet is good". The main menu options for the day were displayed in the hallway. We observed that people had a variety of lunches, some eating the main dish of a meat pie, others opting for a lighter salad option. Lunchtime was a sociable experience where staff engaged people in conversation and facilitated discussions. Some people chose to eat in the garden. Others were supported in their rooms; this was done sensitively with staff chatting quietly to the person through the meal and a telling them what was on each spoonful. In the morning people were offered a bowl of fresh strawberries and bananas which appeared very popular. Throughout the day snacks and drinks were offered to people and staff assisted those who required support. Staff had a range of pictorial aids to support people in making menu choices.

Staff monitored people closely to ensure that they were eating and drinking enough. Most people were weighed on a monthly basis. Any unplanned change in their weight was addressed and staff used a tool to assess whether people were at risk of malnutrition. Those identified as at risk were monitored closely and guidance was sought from healthcare professionals, including from a dietician. Records demonstrated that this had been effective and that with additional support, people had returned to a healthy weight. One care assistant told us, "If they lose weight, we encourage them more". A relative told us that staff would bring chocolates which their Mum enjoyed so that she could eat them when she wanted. Where people were known to refuse meals, staff were directed in their care plans to encourage them with snacks and to offer additional food including milky drinks and finger food on days when they were eating well.

Staff sought advice and new ideas to support people with their dietary needs. One staff member had completed a course entitled 'healthier food and special diets'. The cook had taken inspiration from suggested finger food menus, including for a roast dinner. Staff told us how, following discharge from hospital, one person had successfully started eating again and were now at a healthy weight. The deputy manager said, "We're over the moon with him". In the discharge summary from the dietician we read, 'When I initially assessed (name of person) he was only managing to drink milk and nothing else. He is now managing some mouthfuls of main meals and various snacks'. Another relative told us, "Funnily enough she's improving now, feeding herself and such".

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. The deputy manager said, "It's a close knit home. We work with the families, the district nurses and GPs. We take notice of the professionals. We get everyone involved in the service user's care". Professionals told us that staff contacted them promptly if they had concerns and followed their advice. A specialist nurse practitioner told us, 'I find their liaising and communication skills regarding their residents registered at (the practice) excellent. The manager and staff pass on information and concerns to both the practice and the relatives'. A CPN said, "They're not scared of calling for help and they follow through on advice". In people's care records we saw that they had been supported to attend appointments with the chiropodist, dentist and optician. People had also had their medicines reviewed by the GP.

People moved freely within the home. The premises were clean, neat and well decorated. There were a variety of areas for people to relax including the main lounge, dining room, patio, reception area and upstairs landing. We observed staff supporting people to move around the home, to be in company or to have time alone. Most people were mobile either independently or with the support of staff. Those who could not manage the stairs were accommodated in ground floor bedrooms. The home did not have a lift or stair lift.

Good

Is the service caring?

Our findings

People spoke highly of the staff and appeared happy in their company. One person told us, "I come down at night to see the staff as I think it is breakfast time. They are a good lot these staff, good girls". A relative said, "The staff are really caring. They are like this all the time this isn't for show, because you are here, I like to visit and I know she is cared for and safe". Another relative said, "They really care. All of the staff genuinely care about the residents".

Staff took time with people to get to know them and to understand them. Each person had a keyworker who took the lead in coordinating their care. The home described the keyworker role as, 'To build a relationship of trust and confidence with the resident. To assist management to identify the resident's needs and to assist with the implementation of the care plan'. We observed that staff supported people in a kind and gentle way, taking time to ensure that each person had what they needed and that they felt reassured. The deputy manager told us, "There has to be time for them (service users) to see how they feel. It can change quickly. Dementia affects different people in different ways at different times of day". A specialist nurse practitioner said, 'The staff give time to their residents, have a great understanding and show a tremendous level of commitment and patience'.

Staff spoke of the importance of supporting people to maintain contact with their families and friends. Staff had assisted two people to visit their partners when they were receiving care in a local hospice. Speaking about one couple, the registered manager told us, "We made sure they had quality time together and we supported him when we got back. When she passed away, staff took (name of person) to the funeral". Staff assisted some relatives to visit the home by offering transport to and from the local train station. They told us, "We try to make sure the family stay in touch with them as much as they can". All of the relatives that we spoke with told us that they were kept informed and updated on any changes in the care of their family member. One relative said, "They are really good with him. We can come when we want and we know they will call us if he gets worse even if it is at night or early morning. They are really good to him".

People were involved in planning their care insofar as they were able. An information pack was available to people prior to admission. This contained the service user guide, residents' charter and templates for people to complete detailing how they liked to be supported and what was important to them. The service user guide was presented in a pictorial format to aid understanding. People and their representatives were involved in planning and reviewing their care. One relative told us, "We spent a couple of hours just going through his interests, likes and dislikes. This goes into the history so they know what to talk to him about". Another relative told us how staff had worked with the family to adapt one person's bedroom to accommodate a hoist. This required removing some furniture but meant the person was able to stay in their own room. Staff supported people to attend appointments or to visit the hospital. The deputy manager said, "If they've got dementia and are in a new place that's scary. Staff will always go if the family cannot. I send someone who knows them".

Staff reviewed people's care on a monthly basis, or more frequently if their needs changed. People and their representatives had been involved in these reviews. In each review, staff highlighted who had been present.

This included the person, their relatives, one person's advocate and professionals such as the GP, CPN and social worker. One relative told us, "They have meetings for my mum and they arrange them around me. As I come most days they talk to me all the time but we have regular care plan meetings. I am totally involved in any decision making'. The deputy manager told us, "We also get input from all staff about anything they feel could improve for the person or we need to understand". We found that the service involved people to the best of their abilities. Where people were not able to make their own decisions, staff ensured that the views of those who knew them well and understood their needs were taken into account.

Staff spoke fondly of the people they supported. They were able to share with us about people's interests, talents and hobbies. One staff member said, "Everyone is unique". Another, when asked what made the home a special place for people to live, told us, "It's the kindness, we try to make them feel special and help them to do the things they used to do". Staff were skilled in communicating with people. They described to us the different methods they used, including thumbs up, a smile to indicate a preference and writing things down. With one person, who was an artist, they had tried putting a pencil in their hand to see if they would draw what it was they were wishing to say. One staff member said, "There are lots of ways of communicating but you've got to really know them and focus on them, know their ways". Another told us, "It can take more time to get an answer but they do say".

People were treated with dignity and staff showed great respect for them. The home's vision was to, 'Maintain good practice through a balance of progressive care and old fashioned values of dignity and respect'. Privacy and dignity was one of the home's core values. We saw that discussions on dignity formed part of the induction of new staff and observations of staff practice. The registered manager had signed up to the dignity in care campaign which aims to put dignity and respect at the heart of UK care services. Best practice guidance to staff on privacy and dignity was displayed in the office. This included practical actions such as addressing each person appropriately, respecting decisions and allowing people to do as much as they could for themselves. A folder of further guidance and best practice information was available to staff. As part of the admission information people were asked to detail visitors they'd like to see and those they'd rather not. We read, 'Anyone who comes to the home who is not on either list should be asked to wait until somebody asks the resident whether he/she wishes to see them'. This helped to give people control as to who came to see them in their home.

People were supported at the end of their lives to have a dignified and pain free death. Staff encouraged people to think ahead and share their thoughts on how they would like to be cared for at the end of their life, their preferred place of care and the people they would wish to be with them. This helped to ensure that their wishes would be respected. Staff had attended training in end of life care, including through courses run by a local hospice. The deputy manager had participated in training as part of the Gold Standards Framework (GSF) which aims to improve practice in end of life care and reduce hospital admissions. Staff planned ahead to ensure that they were prepared, such as by involving healthcare professionals or faith groups and ensuring that pain relieving medicines were in stock. The deputy manager said, "Nobody should be in pain, not in this day and age". The clinical nurse lead told us that staff were very good at end of life care and that they ensured the person's comfort. She added, "They do it with such dignity".

Good

Is the service responsive?

Our findings

People had been asked how they would wish to be cared for and about what was important to them. This information was included in a care plan which provided information to staff about the person and their support needs. The care plans were personalised and demonstrated that staff had taken time to get to know people and understand their wishes. There was information about people's lives, important events and their interests. We read that one person enjoyed telling jokes, another enjoyed watching particular sports on television and that a third liked a cup of tea to dunk their biscuits in, although they would not drink the tea. Telling us about one person the deputy manager said, "We get their background so we can talk to them and reassure them. (Name of person) used to paint so we got the arts and craft materials to try and get him to paint. We try to make some link to their past". At a recent relatives' meeting, families had been asked to set a goal to achieve with their relative, such as going out for a meal, shopping or attending a particular event. The idea was that staff would support the person and their family to achieve this by helping with the planning or providing staff to support on the day.

People's care needs were clearly documented. Each person's care plan contained an assessment of their needs, information about their medical condition and detail on how to support them. There were sections including medication, diet, continence, personal hygiene, mobility and sleeping. Each section described the support need, the aim of the support, the action that staff should take and the anticipated outcome for the person. Where healthcare professionals were involved in a person's care, this was documented along with the advice they had given. Staff also maintained updated information regarding people to be shared with other services, such as the hospital. This would help to ensure that people's needs were communicated effectively so that they could receive appropriate care. A specialist nurse practitioner told us, 'Whyke Lodge is very welcoming, the staff are caring, approachable and they are well aware of individual needs of residents under their care, maintaining dignity whilst managing holistic care'.

Staff were attentive to people's needs and responded promptly to changes in their health or wellbeing. There was regular monitoring of people's weight, blood pressure and body temperature, which was reviewed by senior staff. Staff completed observations of people's physical condition. This included their skin, eyes, breath and nails. The deputy manager told us that these observations helped to pick up on small signs which could be an indication of changes in the person's health. The deputy manager described how they had gone back to the district nurses to say that a recently prescribed cream for one person did not appear to be helping. The cream was changed and the person's skin improved. The deputy manager said, "We know because we check". A clinical nurse lead told us, "There are no problems in there whatsoever. I think they're very, very good". A GP told us, 'I have found them to be an excellent and caring home - very responsive to their clients' needs. They integrate well with our surgery and indeed the feedback from relatives of our patients is always very positive'.

Staff were proactive in anticipating people's needs. We saw that a wheelchair had been arranged for one person as staff noticed that their stamina for walking was decreasing. Another person's moving and handling support needs had been reassessed and staff now used a slide sheet to reposition them in bed. A new dental assessment had been introduced for all of the people using the service. This described how the

person liked to be supported to clean their teeth, when they last saw the dentist and if any treatment was required. The registered manager had started to use the services of a domiciliary dentist so that people could be treated in the home. The dentist told us, 'Our service was launched two years ago and (registered manager) was one of the first managers in the region to take it up. He had already identified the need for functional oral health in his residents. He has diligently followed our recommendations and we have witnessed a huge improvement in resident's oral conditions at Whyke Lodge as a result'.

When people were anxious staff were quick to provide reassurance. We read in one person's care plan that they needed a lot of reassurance. There was guidance for staff that this person might need persuading to eat when feeling anxious and that they would need support with transfers since they were at a higher risk of falling. Staff responded skilfully to this person's change in mood and spent time with her to ensure their safety and wellbeing. One relative had written to the home saying, 'I am always amazed at the genuine and individually tailored interest that is shown to each of the residents, particularly bearing in mind their differing and often complex needs. This is seen from you (management) and throughout the staff team'.

Staff knew people well and supported them accordingly. One care assistant told us, "It's different for every person. They want to feel safe". We noted examples of how staff had responded to individuals. For example, when one person was discharged form hospital with a catheter, staff felt that they were unhappy about it. The person was unable to communicate verbally but staff told us the person would raise their eyebrows each time they went to empty it. Staff worked closely with healthcare professionals to see if it could be removed. A clinical nurse lead told us, "They fought for that and he was much happier without it. They look at what is best for the resident". Another person had moved into a shared room at the home and had used the vacant bed to house her dolls. When we asked the deputy manager how many vacancies there were at home they told us there were three but they only considered it was two. She added, "If she shared, where would she put her dolls?" This demonstrated to us that staff knew people well and understood their communication and wishes.

People were involved in planning how they wished to spend their time and were supported to engage in activities. Staff had gathered information about people's interests and hobbies at the time of admission, as well as through surveys asking people what they would like to do. People's care plans included details of what they enjoyed doing and topics of conversation that interested them. There was a busy activity programme at the home, with something planned in the morning and afternoon on every day of the week. This included a variety of visiting entertainers, baking, gardening, art, pet therapy, reading, a visiting ice-cream van, a monthly church service and trips out. The home had strawberries and tomatoes growing in the garden which two people told us they enjoyed picking. Arts and crafts that people had created were on display in the home. They day prior to our visit one person had been to the shops to buy some new clothes; others had enjoyed a cake and coffee at a local tea room or a drink at a local pub.

Staff had received training in providing activities and demonstrated skill as they engaged with people. Throughout our visit we observed people participating in activities and staff supporting them. This included one to one activities such as reading the newspaper and playing cards. People who were cared for in their rooms were visited regularly by staff to ensure that they received stimulation and were not isolated. On the second day of our visit a planned entertainer was late so staff stepped in. There was great hilarity as people danced and others clapped along. People were pleased with the activities on offer. One person told us, "We have great meetings. The one I like is the church one, it's very interesting, very philosophical". Another said, "They take me out, they look after me. I like the staff, they are good to us".

People were asked for their views on how the service was run. There were monthly resident meetings, each of which had a theme. Staff told us that this helped to stimulate conversation and to learn more about

people's wishes. Recent topics included favourite activities, places you'd like to go, your favourite food and fashion. We noted that one person had suggested making a cheesecake for the baking activity, which had since been done. Other discussions had included what to see at the theatre, with the decision being to go to a pantomime before Christmas.

People felt able to share any concerns or ideas with staff. One person told us, "They are good girls; I know I can talk to them". Relatives also told us that they were able to approach staff. One told us, 'My sister has had to raise concerns and (name of deputy manager) has dealt with them, therefore not needing to go any further'. Relatives were invited to relatives' meetings and could access information about forthcoming events and activities at the home on a new section of the provider's website. This area on the website also provided useful information to relatives such as on the meaning of DoLS. In the minutes of the relatives' meetings we saw that staff had encouraged feedback, as well as giving a reminder about the comments box placed in the home's reception.

The provider had a complaints policy and the complaints procedure was displayed within the home. Details were also included in the information guide which people received when they moved to the service. The two complaints covering 2015 and 2016 to-date had been investigated and a full response was provided by the registered manager. Complaints were monitored as part of the service's quality assurance processes. This helped to share learning and ensure that improvements were made.

Good

Is the service well-led?

Our findings

There was an open and happy atmosphere at the home. A relative told us, "They're really friendly to visitors and you can get to know the other residents". Another wrote, 'They always make a person's visitors a drink when they arrive, the same as Mum would have done in her own home'. Staff spoke of it being, "Like a big family". One said, "There are a lot of care homes I could choose from (to work in) but I wouldn't go anywhere else". A trainer who had recently run a course at the home had written saying, 'Thank you for making me feel so welcome when I come to teach. I always look forward to coming, there is a lovely atmosphere and your staff are always engaging and motivated'.

There was strong leadership within the home. The registered manager, deputy manager and team leader formed the management team. They ensured that one of the team was working on each day shift and was available on call at nights. Key responsibilities such as for fire safety, health and safety and dementia champion had been assigned between the team. Staff spoke highly of the management team. One said, "(The registered manager) is very professional and fair to everyone". Another said, "We bring up ideas in staff meetings. We go to management and try to find the best way for the residents". A relative told us, "(Name of registered manager and deputy) care and the staff follow their lead. I've never seen any kind of irritation. They're there for the residents". A visiting dentist told us, '(Name of registered manager) is a 'hands on' manager who is a natural leader that galvanises his staff to follow by example. He is thorough and sometimes demanding and achieves his goals with great interpersonal skills".

People and visitors were encouraged to share any thoughts or suggestions with staff. Information about the home, including newsletters and the results of the quality monitoring were readily available to browse. Staff were encouraged to raise any concerns in confidence. A near-miss reporting procedure was in place. The aim of this was to alert management to any potential areas of risk so that they could take action to protect people. The registered manager attended local registered manager forums. They told us that this helped them to share practice and to learn from experience. Staff felt valued. There were regular staff meetings which provided staff with an opportunity to give their feedback. The team leader told us, "The managers do ask if there are any concerns. We've got a good team".

The registered manager had a system of quality checks and audits to monitor the delivery of the service. This included regular audits of medicines, infection control and accidents as well as a variety of spot checks on records, equipment and cleanliness. The deputy manager worked with the care staff in the mornings providing support to people. She told us, "I check on the service users. I work with the girls. I like to be out there". This helped to monitor the quality of care that people received and to address any issues or changes in a timely way. The regular monitoring and corrective action had delivered improvements in the service and in the care that people received. For example, in the annual review of the accident audit, we read, 'We have reduced the amount of no injury accidents and minor injury accidents by implementing pressure pads and providing one to one care for at risk clients at key times during the day'. The figures demonstrated that the number of accidents without injury had reduced by 36 percent between 2014 and 2015. Furthermore, it was noted, 'The number of emergency hospital admissions half reduced. This is due to staff training and guidance on admissions avoidance and encouraging service-users to complete advanced care plans'.

People, visitors and staff were asked for their views on how the service was run. In 2015, eight people returned the surveys and all stated that they were satisfied. The questions included if staff were kind and friendly, if they had sufficient choice and if staff were available to sit down and talk with them. All of the 28 visitors who responded said that they were happy with the home environment, that staff were polite and treated people with respect. Staff confirmed in their responses that they were familiar with the home's aims and objectives, that they were satisfied with the training available and that senior staff were available for advice when needed. One visitor had written, 'Very friendly, food good, high standard, excellent atmosphere'.

Each year, the registered manager reviewed the results of the year's audits and produced a report. This considered each of the quality assurance measures in place, both internal (care plan reviews, staff meetings and questionnaires) and external (results of inspections by the fire service, environmental health, CQC and equipment maintenance). In the summary we read, 'The review of the home's quality control system showed that Whyke Lodge continues to provide a high standard of care to service users. The only action point is for staff to continue to encourage service users to use their mobility aids'.

We found that the service was providing a high standard of care to people and that systems were in place to monitor the ongoing quality of the service and to further develop it.