

WCS Care Group Limited

Woodside

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

We carried out this inspection on 26 August 2015. The inspection was unannounced.

Woodside is registered for a maximum of 40 people offering accommodation for people who require nursing or personal care. At the time of our inspection there were 38 people living at the home. Two people were in hospital. Several people using the service were living with dementia and had high level care needs which required the support of two care workers.

A requirement of the service's registration is that they have 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was in post and had been since April 2015. This person was on annual leave at the time of our inspection.

Summary of findings

People who were considered to lack capacity were not always supported in line with the Mental Capacity Act 2005 (MCA). Staff obtained consent from people before supporting them, however care records did not always show people had provided consent to their care.

There were processes to minimise risks to people's safety, however care records did not always reflect people's current care needs, so we could not be assured that all risks were being managed. Following assessment, arrangements had not always been made so that equipment was available for people's use in order to maintain their safety, however the provider told us staff had put in safety measures to reduce the risks.

People told us they felt safe living at the home and could raise any concerns they had with staff. Staff were trained in safeguarding people and understood how to protect people from abuse.

People received their medicines in a timely way from staff trained to administer them. Overall there were enough staff to support people, however people did not always receive support at the times they preferred.

Checks were carried out prior to staff starting work to ensure their suitability to work with people who lived in the home. Staff received training which gave them the skills and understanding to support people with their health and social care needs.

People told us staff were kind and respectful and had the right skills to provide the care and support they required.

Staff treated people with dignity and respect. People told us they enjoyed the food at the home and had a choice of meals and drinks, which they could have at times to suit them.

People were referred to other health professionals when required, however this was not always done in a timely way. Care records contained relevant information to help staff provide people with personalised care. People were involved in their care and were asked for their views and opinions about the support they received. People told us they enjoyed the activities on offer at the home.

People told us they could raise any concerns with the registered manager, and these would be listened to and acted upon. People, relatives and staff told us the management team were approachable and responsive. The management team kept people informed of the proposed changes within the service. There were processes to understand the experiences of people who lived within the home. This was through regular communication with people and staff and a programme of other checks and audits. However, audits to monitor the quality and safety of the care provided had not identified information on care records was not always up to date, and assessments were not always completed to assess people's abilities to make decisions.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

People told us they felt safe. Staff were confident in how to safeguard people from abuse and actions to take if they had concerns. Risk assessments were on care records but did not always reflect the current risks to people's health and wellbeing, and how to minimise these. Following assessment, arrangements had not always been made so that equipment was available for people's use in order to maintain their safety, however the provider told us measures were taken to reduce these risks.

Medicines were stored safely and people received these as prescribed. There were enough staff to keep people safe, but staff were not always available at the times that people would like. Recruitment checks were carried out and reduced the risk of unsuitable staff being employed at the service.

Requires improvement



Is the service effective?

The service was not always effective.

Where people lacked capacity, assessments were not always completed and decisions were not always made in their best interests. Staff received training on how to meet people's needs. Referrals were made to other healthcare professionals when required to support people's needs and maintain their health and wellbeing. However, these were not always done in a timely way. People enjoyed the food and different dietary needs were catered for. A choice of food was offered and people could access drinks and snacks when they wished to.

Requires improvement



Is the service caring?

The service was caring.

People were encouraged to be as independent as possible. Care was provided ensuring dignity and respect, and staff treated people with kindness and affection. Everyone spoken with told us staff were caring in their approach and we saw examples of this during our visit. People were involved in decisions about the care they received.

Good



Is the service responsive?

The service was responsive.

Staff knew people's individual needs and preferences. Group and individual activities were on offer for people at the service and people were encouraged to pursue their interests. People knew how to raise complaints and these were dealt with quickly and thoroughly.

Good



Summary of findings

Is the service well-led?

The service was not always well-led.

People and staff were positive about the management team and the improvements being made at the service. Systems ensured the home environment was safe. However audits had not identified information on care records were not up to date, and assessments were not always completed to assess people's abilities to make decisions and ensure their safety. Staff told us managers were approachable and issues raised were addressed quickly. The registered manager was responsive to new ideas to continue improvement at the home and kept people updated about the planned changes within the service.

Requires improvement



Woodside

Detailed findings

Background to this inspection

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

The inspection visit took place on 26 August 2015 and was unannounced. The inspection team comprised of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The inspection was a planned comprehensive inspection brought forward following some concerns we had received about the quality and safety of service provided.

We reviewed the information we held about the service. We looked at information received from relatives and visitors, we spoke to the local authority commissioning team and reviewed the statutory notifications the registered manager

had sent us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

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. This was received prior to our visit and we used the information to plan our inspection. This reflected the service we saw, and the improvements that had been made.

We spoke with nine people who lived at the service and five relatives. We also spoke with 15 staff including the deputy director of operations, two areas managers, deputy manager, care staff, the cook, housekeeper and laundry person. We looked at six care records and records of the checks the registered manager made for assurance that the service was good. We observed the way staff worked and how people at the service were supported. Due to the complex needs of the people at the service, some people were not able to discuss their experiences of the care and support they received with us.

Is the service safe?

Our findings

Assessments of risks associated with people's care and support had been undertaken. These were for areas such as nutrition, mobility and skin care. Where risks had been identified, plans were in place to manage those risks. A staff member told us, "We have to be very, very mindful of pressure sores. That is why we have turning charts and they have to be on time. We know how important it is. We know if we don't, they will deteriorate." However, information recorded did not always reflect people's current needs and the associated risks. For example, one person was recorded as being at risk of weight loss as they had lost 4kg in five months. A referral was made to the dietician in March 2015. Weights were then recorded monthly by staff to monitor their weight. In May 2015, staff recorded the person weighed both 46.9kg and 44.2kg, and in July 2015, both 42.9kg and 45.4kg. It was unclear if this person was gaining or losing weight. We asked the deputy manager about this. They told us they were unaware of this, the recording was not clear and they did not know why staff had recorded different weights for this person each month. Inaccurate recording meant the person was at risk of not receiving the support they required to manage their weight.

We saw a mobility care plan for another person dated July 2012. Staff told us this had been reviewed in January 2015, although this was not clear. The person's current care plan stated that they mobilised independently and were able to get in and out of bed on their own. However, a staff member told us the person was very unwell with an infection, were no longer able to mobilise independently and needed the support of two staff for all care. There was no information in this person's care plan about what equipment staff should use when supporting the person. For example, on some occasions staff had to use a hoist when transferring the person from their bed to a chair. However, there was no information recorded about this or about the correct sling size to use. The management team told us such information was relayed to staff in the handover meeting between shifts, but this posed a risk that important information may be lost as it was not reflected in their care plan. We asked a staff member about this person, and they had a good understanding of their needs. However, staff who had not attended handover such as agency staff would not have the necessary information to care for the person safely. On the day of our visit, there was an agency worker at the service and they told us that they

had not attended the handover meeting. The deputy manager told us the care plan should have been updated to reflect these changes and said this would be done now. Risks to people's care were not always recorded accurately to ensure people were kept safe.

For another person we found that their risk assessment had not been reviewed following a fall which resulted in a serious injury. In addition, following this, the person returned from hospital without the assessed safety equipment being in place. However, the provider told us staff had put safety measures in place to reduce these risks and the equipment was in place later that day.

People told us that they felt safe at Woodside. One person told us, "Safe yes, I think so, my things are safe." A relative told us, "I think it is secure."

Prior to staff starting at the home, the provider checked their suitability to work with people who lived there. Staff confirmed that all the background checks were completed before they were able to start work. One staff member told us, "All my checks were done; I was totally checked by the manager." This included contact with their previous employers and the Disclosure and Barring Service. The Disclosure and Barring Service (DBS) assists employers by checking people's backgrounds to prevent unsuitable people from working with vulnerable people. The provider ensured that, as far as possible, the staff employed were suitable to support people who lived at the home.

Staff we spoke with told us they had a good understanding of how to safeguard people and they had received training about this. One staff member told us, "If I was walking along and saw something, I would not keep it to myself. It could be abuse like shouting at someone or not providing care properly. I would tell my boss, the managers or someone higher." Another staff member told us, "Safeguarding of resident's means keeping people protected. If I see or hear anything, I would report it, I would not condone it." Staff demonstrated an understanding of abuse and the various forms it could take. One staff member told us, "There are several types of abuse. You have to watch out for bruising. We have a body chart in the care plan." Another staff member told us, "It's mistreatment of a resident. Handling them badly." A staff member told us a person had recently discussed some money concerns with them and they had reported it to the registered manager immediately. Staff told us they were confident the registered manager would follow concerns up. A staff

Is the service safe?

member told us, “I would follow it up as well and make sure they did. I look on it as though the resident is my mother and protect them.” There was a whistleblowing policy in place. We asked three staff about this, but they were not aware of it. Another staff member knew there was a whistleblowing policy, but they were not clear what this meant. Staff were confident in recognising potential different types of abuse and actions to take, however some staff were not aware of the provider’s whistleblowing policy.

We looked at whether staff were available at the times that people needed. We received mixed responses. One person told us, “Yes they come quickly, the odd times they are busy.” A different person told us, “When I press the call bell at night they come quickly and help.” And one staff member told us, “Yes, there are enough staff.” However one person told us, “No, I was in the lounge once and there were no staff, I had to get up to a lady three times who kept trying to get out of her chair. There used to be more people about.” Other staff told us, “The workload is heavy, with people with dementia it’s hard, extra staff would help,” and “We have got about seven doubles and you are struggling to get them up before 12.00pm. If you get them up when it is dinner time, they don’t know half their day has gone. It is very rare to get everyone up before 12.00pm and then they don’t want their dinner because they have just had breakfast.”

We asked if staff had time to sit and chat with people. One staff member told us, “Probably in the afternoon or on the late shift. It is just so busy in the morning.” Another staff member told us, “A lot of the paperwork is taking over from the care. You feel as though you don’t have time for the residents.” We asked whether there were enough staff to be able to supervise people whilst using the communal areas of the home. A staff member told us, “You can’t watch them all the time. You keep popping in and checking all the time. Make sure their frames are in front of them in case they get up. If I am going to be a long time, I will go and tell [manager].” Staff told us managers would support them with care when required. Eight members of staff were working on the day of our visit over three floors, with support of the deputy manager as one staff member was absent due to sickness. This was the number of staff the management team required. The deputy director told us that a dependency tool was used to calculate staffing levels based on the needs of people. However, they recognised that there needed to be a ‘more flexible staffing rota’ to

cover different areas and they were reviewing this. Agency staff were used at times to cover sickness and absence and there was a number of staff who worked for the provider, known as ‘bank’ staff, who worked as and when required. We saw that whilst staff were busy, overall they were available when people needed assistance and had some time to sit and chat with people in the afternoon. Whilst staff thought people were safe, some staff told us that because most people required additional support, it took them a long time to assist everyone with personal care in the morning. This meant that some people were not being assisted to get up at a time they preferred.

We looked at how people’s medicines were managed. One person told us, “I get my medication when I should, three times a day.” One person had diabetes and self-administered insulin and this helped to maintain their independence.

Medicine was given using a ‘Bio dose’ system where medicine is administered from pre-prepared packs. Each person had their own medication file with their photograph on the front to reduce the risks of medicine being given to the wrong person. Staff received medicine training and were observed giving medicines before being considered safe to do so without supervision. Competency assessments were completed regularly by the management team to ensure staff continued to give medicines safely and in accordance with good practice. A medicine audit was carried out by the management team monthly to identify and analyse any issues. A staff member told us, “They check your MARs charts to check you have signed.” Medicine administration records had been signed by staff to show they had administered the medicines. However, we saw handwritten amendments to MAR charts had not always been countersigned by another member of staff, in accordance with good practice, to confirm they were accurate. A protocol was in place for people who received medicine ‘as required’ and care records documented how staff would know when someone with limited communication may require this. For example, through facial expressions or by pointing to where the pain was. We observed a staff member administering medicine and they asked if people had any pain and explained to people what each medicine was.

Is the service safe?

Medicine was kept in locked medicine trolleys. Medicines were stored in line with manufacturer's guidelines, then disposed of safely to ensure people were protected and people received their medicine when they should from staff trained to do so.

Checks had been undertaken to assess the safety of the service. Accidents and incidents were recorded and we saw these were up to date and had been analysed to identify any trends. Personal emergency evacuation plans (known as PEEPS) were available for people detailing care and mobility requirements so they could be supported in an emergency. One staff member told us, "PEEPS are on top of the fire panel, they are updated monthly." These were kept in a central location so staff could access them quickly. We saw these were reviewed monthly and staff had signed to

confirm they had read and understood them. A staff member told us what they would do in an emergency, "I have had training and I know the procedures." We saw up to date checks around fire procedures, equipment, emergency procedures and water temperatures. These were reviewed monthly by the housekeeper and any issues identified were addressed to keep people safe.

Checks were carried out to ensure the buildings and equipment were safe for people to use. The home was well maintained and the services of a gardener and maintenance people were employed to do this. The registered manager had systems in place to protect people from harm, as they maintained health and safety procedures.

Is the service effective?

Our findings

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. This is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

We could not be sure the rights of people who were unable to make important decisions about their health or wellbeing were protected. A staff member told us, “Some can (make decisions), families make decisions if they can’t.” We were told that complex decisions would involve the family and their doctors, and maybe social workers. The deputy manager told us several people at the home were considered to ‘lack capacity,’ however we did not see capacity assessments on any care records. For example, one person had a dementia diagnosis, and was deemed to ‘lack capacity’ by the deputy manager but there was no recording on their care record about their level of understanding or ability to make decisions. If a person lacks capacity to make an important decision, a meeting is required with people closest to them to make a decision in their ‘best interests’. Capacity assessments had not been completed to show how people were being supported to make decisions.

Records showed one person was at high risk of ulcerated legs and the district nurse had advised they should receive a shower every other day to prevent the ulcers getting infected. We were told this person consistently refused to have a bath or shower and they often went for long periods of time without this. On the day of our visit, the last recorded shower was on the 11 August 2015. On 12 August 2015 a note in their records stated they had a sore sacrum but had refused to allow the district nurses to look at it. This person’s decisions about their personal care had a potential effect on their health and wellbeing. Staff were unclear whether the person had the capacity to understand the consequences of refusing personal care. We were told this had been discussed with a social worker two years ago, but records showed the person had suffered a decline in their physical and mental health over the last few months. Although staff were recording the person’s skin was looking red and sore, there had been no recent discussion with

relevant professionals or family members in relation to the person’s capacity and how this should be managed in the person’s best interests. A referral for an MCA assessment and best interest meeting had not been considered.

People told us staff asked them for their consent before supporting them with care. One person told us, “Yes, they never do anything without asking me.” A staff member told us, “When I am in a room with a resident, I always ask them what they would like first and if they are happy with it.” Staff told us they understood the importance of gaining consent from people and that people had varying abilities as to whether they could make their own decisions. However, we looked at care records around consent. We saw one person had a consent form signed by a family member around photographs being taken. There was no indication of whether this person had the capacity to consent themselves or not. For another person, a staff member had signed a consent form for photographs to be taken and it was unclear whether the person had consented to this or not. Staff understood about the need to obtain consent when supporting people, however care records did not reflect that consent had been sought for people in line with their abilities to do so.

One person at the service had a DoLS authorisation. Advice had been sought from the local authority whether anyone else at the service was being deprived of their liberty and they had been advised no one else required an assessment. During our inspection we saw two people in wheelchairs with lap straps on. One person had moved to the service recently. Both people appeared confused and anxious and were trying to get out of the wheelchairs, asking to leave and for the strap to be removed. We discussed this with the management team and were told they had submitted an urgent DoLS application for one of these people however we were unable to see this on their care records. They had not considered whether the second person required a DoLS. Neither person had a capacity assessment in their care plan to say they were able to consent to these restrictions and there was no evidence of any best interest decisions that these restrictions were necessary to keep them safe. We saw some people at the service who may have been having their liberty deprived, and the deputy director of operations told us they would seek further advice from the local authority regarding this.

Is the service effective?

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

People told us staff had the skills and knowledge to care for them effectively. One person told us, "Staff know what they are doing, they're all very good." A different person told us, "The staff are adequate and they know what to do, you don't get excellent care, but they look after you, I think it's very good for what it is."

Staff were made aware of their roles and responsibilities when starting employment. One staff member told us, "Yes, when I started I was taken around the home, shown the routines." Another staff member told us, "I was shadowing for a while. I did my manual handling a month after I started. I wasn't allowed to move anyone until I had the training." We saw new staff were given job descriptions and a staff handbook, which detailed their duties and responsibilities. The induction process gave staff the skills they needed to effectively meet people's needs when they began working at the service.

Staff received training relevant to the health and social care needs of the people who lived in the home. An in-house trainer carried out some of the training and staff told us they were good at making the training interesting. Recent training had been provided around dementia awareness. One staff member told us about this course, "I learned to understand the residents more, what to do if they seem unhappy and how to talk to them." Another staff member told us, "It is good. When I first started I had all the training I needed. We are going through training now for nutrients and personal care. It is a refresher but you always learn something new as it is always changing." Other training undertaken was around areas such as health and safety and equality. A training schedule was completed to show when training had been undertaken by staff and when it was next due. Staff felt the training they received helped them do their jobs effectively and they were supported to develop and keep up to date with training by the management team.

A 'handover' meeting was held at each shift change where information was passed on to staff about any changes to people's health or well-being. A staff member told us, "For every resident you have cared for during the day, you have a care diary and you write in it what has happened to them during the shift that you feel people need to know. Everything that would be beneficial to the next person

coming on the shift." Communication between staff assisted them to provide a continuity of care to the people they supported, which reduced the risks that care provided would not be suitable.

People had a choice of food which met their dietary needs and preferences. One person told us, "The food is very good, they come around the day before and say what's on the menu. You can ask for something else." Another person told us, "It's marvellous food, you can choose." The menu was seasonal and on a four week rotation. People were offered two options for a hot lunch and could request an alternative and this would be provided. The cook told us they ordered specific food if people requested this. A menu was displayed in each lounge showing the choices that day. Meal times were flexible and we saw people ate at different times and in places of their choice. We saw people being supported to eat by staff and this was done at a pace to suit them. Some people had eaten a late breakfast and staff told us lunch could be kept until later at a time they preferred. Snacks and drinks were available for people to help themselves and a fridge on each floor contained some people's own foods and drinks. One person told us, "I get what I want to drink."

People's dietary needs and preferences for reasons of health and religion were catered for. One person followed a vegetarian diet, another person was diabetic and other people required a soft diet. The cook was aware of people's specific dietary requirement and we saw these were met.

Food and fluid charts were completed but these did not provide an accurate record of quantities consumed. For example, a 'half' or 'quarter' was written, but not the original quantity, in order to assess the amount taken. At 5.25pm we saw one person had no fluids recorded after 1.00pm. We could not establish whether an accurate record of this had been kept. The amount of fluids people had taken were not being totalled to give an indication when staff may need to encourage people to drink more to prevent the risk of dehydration. We raised concerns that one person's care record stated they did not receive any fluids for up to 16.5 hours. We were told by the area manager it had been identified this person did not need to be on a fluid chart. However, they went on to explain they were currently doing a piece of work around food and fluid charts, and had identified some concerns with these records.

Is the service effective?

People were supported by staff to access health professionals when required. One person told us, “Yes, they call the doctor straight away.” A staff member told us, “We are also straight on to SALT (speech and language therapy) if someone is struggling with the food they are given and they are coughing a lot.” One person had been referred to a dietician as they had lost weight and another person had been referred to the GP on several occasions as they had repeated urine infections. Visits from GP’s, district nurses and chiropody were recorded on care records. However, one member of staff raised a concern that senior staff were not always responsive when people were ill. They told us that if they raised a concern about people’s health, they

didn’t feel it was actioned quickly, “They have got to be really ill before they get something done. It’s like water infections; it is not good at all.” We saw on one person’s care records they had lost 8kg in weight over 7 months. We raised this with the deputy manager who confirmed that the nutritional care plan had not been reviewed for this person and a referral to the dietician had not been made. Overall, we saw daily records detailed changes in people’s health needs and wellbeing, and care records detailed professional visits. People received support from health professionals however sometimes this was not done in a timely way.

Is the service caring?

Our findings

People we spoke with were positive about the care staff. One person told us, “Today I am sitting here and I have never been so happy. It’s all the smiley faces.” Another person told us, “The staff are nice and kind.” During our visit we saw several positive interactions, with people being supported by staff with kindness, affection and respect. For example, one person had taken their blouse off when sitting in the lounge. The member of staff said, “This is a lovely blouse. Would you like me to help you with your buttons?” Then kindly and discreetly supported them to put it back on. Staff showed confidence in caring for people compassionately.

We asked staff why they thought they provided “caring” care. Different comments included, “I make them happy. I put music on and I sing along and they join in. It is just trying to make their day special. I talk about their families,” and “I tend to think when I am doing something, would I put my own mother in this situation.” Other staff members told us, “Good communication skills, treating people equally, patience and being motivated,” and “When I talk to the residents I like to make them smile.” One person had gone into hospital and as staff had been unable to contact their family member who was on holiday, staff visited this person in hospital to ensure they had some visitors. Staff took pride in supporting people with kindness and showed a genuine interest in people and their care.

Relatives were encouraged to be involved in their family member’s care. There were no restrictions on visiting times and relatives could have a meal at the service without a charge if they wished. Visitors were able to help themselves to drinks. One person was visited daily by their spouse, and staff told us this relative assisted their family member with care as this was the couple’s preference. Staff supported them to do this.

People were encouraged to maintain their independence, however staff supported people in the ways they preferred. One person told us, “I think the staff are wonderful, staff run

my bath get my towels help me into the bath then leave me to wash myself. Then they return to do my back.” A staff member told us they made sure that, “The person remains in control with their care.”

Staff supported people to make their own decisions. One person liked to lie on the sofa in the lounge after breakfast and sleep, they were encouraged to do this, as this had been their usual routine in their own home. We saw on one person’s care records they had requested for female only care staff to support them and this was provided. We did not see anyone with specific cultural needs at the service at the time of our inspection.

Bedrooms were personalised and people were able to bring in their own furniture if they wished to. Some people had a fridge in their rooms and one person told us they liked to store their drinks and chocolate in this.

Staff treated people with dignity and respect. One person told us, “Yes staff shut the door, they cover me over [when assisting with care].” Another person told us, “I’ve always found them good, the way they speak.” A relative told us, “There is a slight difference depending on staff; some will go the extra mile. When there is agency on, it is never the same. The staff always draw curtains and cover [person] with a towel before carrying out personal care. They focus on [person] and talk to them, not to each other. In the dining room they join in the chit chat with staff, they enjoy that.” A staff member told us, “We make sure we use people’s preferred names,” and we saw people being called by them. People had door knockers on doors and we saw staff using these. Each floor had a small ‘quiet’ room where people could sit away from the group or this could be used by visitors for privacy. During our visit we saw one person undressing with a door open and alerted staff to this. A relative told us they had observed staff continually encouraging this person’s privacy and closing their door, however the person would not always accept this. People were able to lock their bedroom doors at night if they wished to and staff used a master key to open this to carry out nightly checks. Staff were confident in supporting people and aware of the importance of treating them respectfully.

Is the service responsive?

Our findings

People we spoke with had positive views about how their care and support needs were met. One person told us, “I’m treated well, I press the buzzer when I want something, anything I feel that is wrong, they always look after it.”

Prior to people coming into the home people were assessed to see if their needs could be met by staff and they were suitable to live with the other people there. People could come and visit for lunch or have an overnight stay to ensure the home was right for them. If a person was assessed in hospital and was unable to visit first, the management team had previously taken their photographs of the home, to help people decide if it was suitable for them or not.

People had copies of their own daily care records and were involved in planning their care. One relative told us, “I’ve not been involved formally in the care but have been informed. [Person’s] notes are there (pointing to a file in the bedroom) I can read them, nothing is hidden.” Staff held care plans which contained further information about people’s care needs. A staff member told us, “The care they receive is brilliant, they are well looked after.” Staff told us people were encouraged to be involved in reviews of care and contribute to these discussions. A keyworker system was in place so named workers supported people consistently and we saw photographs of these workers displayed in people’s bedrooms. Staff told us they updated care records as people’s needs changed and then managers reviewed these monthly. However, we saw one person’s care plan identified that a person had good verbal communication. This was dated June 2013 and it had been reviewed in January 2015. When we spoke with this person it was difficult to understand what they were saying because of their declining health but this had not been reflected in their care records. This person’s care plan did not reflect their current care needs in relation to communication and the manager’s review had not identified this. We discussed this with the deputy manager who said this would be updated.

Staff were skilled in supporting people living with dementia. Throughout the day we observed good examples of compassionate, effective interactions with people who were anxious due to their condition. We asked staff how they supported people if they were resistant to accept support. They told us they would try a different staff

member or sing to them to relax them further. Staff told us they had received training in supporting people with behaviours that could be challenging. A staff member told us about one person and said, “I talk to them nice and quietly, they will sometimes have none of it. [Person] orders me away, so I will go away and get someone and then it is okay.” However, this member of staff told us there was no information in the care plan to guide them as to how to manage the situation if the person did become upset and agreed this would be addressed now.

We saw ‘dementia friendly’ signage on bathroom doors to support people to orientate to these rooms. ‘Dementia care boxes’ were placed outside bedrooms and we saw these had been created with the involvement of people and their families and contained important information about people’s lives such as photographs. We looked at some of the memory boxes that had been completed. They contained a good range of items that gave a picture of the person and snippets of information that provided staff with topics to talk about that the person understood. For example one person liked decorating and enjoyed a ‘milky coffee’, and this information was in their memory box.

Staff cared for some people who had limited communication. One staff member told us, “You can tell by [person’s] expressions. When you have worked with them for a while you know. If they are holding their head, I would know they had a headache. It is common-sense a lot of it is. It is just looking.” One person used a visual aid book to show staff how they felt and pointed to pictures to aid communication. Staff were skilled in knowing and interpreting people’s needs when they had limited verbal communication.

Staff we spoke with told us how they supported people and responded to their individual needs. Most of the staff we spoke with had a detailed understanding of people and their backgrounds and how this could impact on their behaviours within the home. An assessment was undertaken to assess people’s histories, likes and dislikes. One staff member told us a person used to work nights and went on to explain, “I think that is why they are up at night walking around.” A person had previously had a career involving numbers and figures. One of the night care staff spent time with them doing some calculations. Another staff member spoke in detail about the hardship a person had faced when they were younger. The staff member demonstrated a good knowledge of this person and their

Is the service responsive?

background and personality. Other staff members were also able to tell us about the people they cared for. We asked why staff thought it was important to know about people. Staff told us, "It matters a lot so you can have conversations with them all time. You have got to chat to them and that is how you find out about them," and "It brings us closer to them. It is part of their life and if they want to tell you, then you should listen. If you can't form a bond with them, you are not a good carer." The staff knew the people they cared for well and used this knowledge to provide care which was responsive to the person's needs.

People were involved in planning activities and were encouraged to pursue their interests. People had life diaries in their rooms detailing what they had done during the day and whether they had enjoyed this. One person told us, "Yes, there are things going on to do." Another person told us "You can make your own decision as to how you want to spend your day. You want stimulation, not medication." The provider employed two activity co-ordinators at the home. An 'Oomph' exercise class was held on most days. We observed the morning session of this activity and saw people were carrying out simple exercises to music and appeared to be enjoying the activity. A church service was held weekly in each 'household' and a hairdresser came in weekly or on special occasions. A computer was available for people to use and the activity co-ordinator supported

some people to access the internet if they wished to. Staff told us another person enjoyed playing games on the computer. We were told this was a specialist dementia software for 'reminiscence therapy'. We saw an activity planner displayed in a communal area, and ball games and a sing song were planned on some days. The cook told us they were planning to start a cookery club which had been successful at another of the provider's homes. The week of our visit was 'sports week' and events had a sports theme. People had opportunities to pursue their interests and could do this either on their own or with a staff member supporting them.

People we spoke with told us they were aware of how to make a complaint. One person told us, "Yes I could complain, straight away, no problems." Another person told us, "I've got no complaints, I could tell staff." Information was displayed in the entrance hall about how to make a complaint. We saw seven complaints had been raised this year. The complaints were recorded and a written response had been given to them. One person had complained about the food and we saw a response to this and actions had been taken as a result of this. People had the opportunity to raise any concerns and these were responded to by the management team to people's satisfaction.

Is the service well-led?

Our findings

We spoke with people and staff about the provider's management team. One person told us, "I could talk to the manager, [person] is approachable." A staff member told us, "If I had a problem, I could tell [manager], they are a very good listener."

The management team completed monthly audits of care records including records of personal care. However these audits had not identified the shortfalls in relation to records which we had found during our inspection such as risk assessments not being updated or mental capacity assessments not being completed. The local authority had visited in April 2014 and we saw one action was to ensure changes to an individual's care needs were consistently recorded. Other actions such as recording people's preferences and needs had been completed. Overall we saw the actions identified by the local authority had been actioned, however changes to individual's needs were not being consistently recorded on care records.

The home comprised of three floors, known as 'households'. People had access to all areas of the home via a lift, which they were able to use independently if they wished. The management team consisted of a registered manager, a deputy manager and three care co-ordinators, which were new positions. The care co-ordinators were considered 'supernumerary', so were not included in the number of staff on duty for care provision and could support other staff when needed. This meant that there was management cover every day of the week. A relative told us, "There has been a change in manager; I've been very impressed with the manager, they were here at the weekend. They said if I expect staff to be here at weekends then I will also be here. They give staff more responsibilities, giving deputies delegation skills." Information was displayed in the entrance hall so visitors knew who the senior staff on duty were. On the day of our inspection the registered manager was on annual leave and we were supported by the deputy manager, two area managers and the deputy director of operations.

The registered manager encouraged people to be involved in the running of the home. Comment cards were provided in the reception area for people who wished to give feedback about the service they received. We saw one comment card written by a relative which said 'Carers as always are dedicated, caring and lovely.' Other positive

comments included, 'She was always treated with the utmost respect and dignity and during her time at the home she was happy, safe, secure and stress free,' and 'It's all about good loving care, and that is what she got.' An annual survey had recently been given to people and relatives and 14 responses had been received so far. People said they were either very satisfied or quite satisfied with the service they received. We saw some comments about breakfast being late and snacks could be repetitive. The deputy director of operations told us they would be analysing the responses and responding to individual concerns shortly. The management team listened to people's views and suggestions and acted on these where possible.

A group meeting involving people who lived at the home was held every four months. We saw the last meeting was in July 2015 and 7 people attended. Comments included not all people knew who their keyworkers were, however we saw photos of keyworkers now in some of the rooms. At the previous meeting it had been decided that herbs would be grown in the home's garden. This had now been arranged. As part of annual quality assessment, people, relatives and stakeholders were being invited to a drop in session in October 2015 to consider what the service had achieved and what they could do better. People who could not attend were invited to provide feedback before this. People were involved in discussions around any concerns they had and the provider made changes were possible in response to this.

The provider encouraged staff and relatives to 'work together'. The first meeting of a 'Relatives and Staff Dementia Group' was planned for September 2015. The aim of the group was to share information and develop supportive relationships for people and their relatives. The home was part of the 'dementia friends' scheme also. People had opportunities to be involved in the way the care was provided and encouraged to support each other.

Staff told us they felt supported by the management team. Staff received three monthly supervisions and had an annual appraisal. This gave them the opportunity to discuss their work performance and training and development needs. One staff member told us they were supported, "Regularly" and a different staff member told us, "It is quite handy if you want to discuss something that is bugging you. It does give you a chance to have a one to one conversation and if you have got any problems you

Is the service well-led?

just go and talk about it.” However, some staff members we spoke with said they had not had supervision for some time, but were having them now. We saw supervision and appraisal planned dates displayed on a wall in the staff room. Staff meetings were held monthly and we saw the management team had recently facilitated a discussion with staff around the use of social media. A staff member told us, “We can tell them what we think. The problem with the staff meetings is you can’t always get off the floor to attend them.” Other comments were, “We can raise things if we are not happy with them.” When asked if the management team responded, this staff member told us, “Sometimes, it all depends what the problem is.” Staff told us about the new role of care co-ordinators, “It has taken some getting used to, three care co-ordinators. Each one is looking after the floor but they spend time in the office doing the management side of things. There is always one of them in the building which means all weekend is covered. If resident’s family come in, there is always somebody they can talk to,” and “They are in charge of the floor. We know who to go to if we are concerned about anything.” Staff felt supported in their roles by the management team. The senior management team audited staff supervision records to ensure they were carried out, and met the needs of staff.

The deputy director told us they were proud of the culture at the home. They told us their ethos was, “To keep carers caring.” The provider had a care charter detailing their values and principles for staff. The principles included play (fun/creativity), make their day (consideration, kindness), choose your attitude (your approach) and be there (listen and connect with people). A quarterly newsletter was issued which contained information around others homes the provider had, news and information. A ‘Friends of Woodside’ group supported the home with fundraising and practical support. The group was comprised of people whose relatives had previously lived at the home. Fund raising activities had provided a summer house in the garden which was used for meetings and training. The management team worked hard to create a positive culture at the service and involved the wider community in doing this.

The deputy director told us they were committed to continual improvement of the home and the care people received. A staff member told us the area they worked in had improved with some new equipment recently and this

had made their work ‘a lot easier’. A different staff member told us, “They ask for your input and they will get you what you need to do your job.” The deputy director told us there was a need for modernisation at the service to ensure it would be ‘fit for the future’. Their aim was to rebuild the home with shared facilities, bigger bedrooms and lounges, en-suite showers, spa bathing facilities and assistive technology. A decoration programme was continuing, although the home was due to be redeveloped in 2016.

The provider was developing a new home, ‘Castle Brook’, in Kenilworth which was to be ready in November 2016. Information about the development was displayed within the home and ways people could input into the planning. Meetings had been arranged for people and their families to answer any questions and the management team were arranging trips to the site to see the new development. People were being given the opportunity to move to the new home or to another service. Woodside would then be rebuilt by 2018. Quarterly management forums were held by the registered manager where staff had an opportunity to talk to the senior leadership team during ‘question time’. This information was then shared across the staff group.

To assess the quality of care provided, the deputy director told us the board of trustees undertook themed visits and ‘sleepovers’ in the home. This was so that they could experience what it would be like to use the service. They told us they encouraged ‘dialogue’ between people and the management team. There was a ‘hotline’ for people, relatives or staff to call if they wished to speak with the chief executive directly in confidence. The management team had sought additional feedback from some ‘experts by experience’ via a national charity. These people had experience of similar services and had been invited to visit twice yearly and give feedback on the home and any changes or improvements recommended. We saw the outcomes of the last visit were positive. The management team were proactive in seeking views of others around quality of care.

The management team was able to tell us which notifications they were required to send to us so we were able to monitor any changes or issues with the home. We saw we had been notified of these and there were not any we were not unaware of.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment was not provided with the consent of the relevant person. Regulation 11 (1) (3)