H. W. Group Ltd

Woodlands House

Inspection report

205 Woodlands Road
Woodlands
Southampton
Hampshire
SO40 7GL

Tel: 02380292213
Website: www.hartfordcare.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Woodlands House is part of the Hartford Care Group and is an older style residential home located within the New Forest set within large grounds and gardens. The home consists of the main building which has been converted to provide care and accommodation for up to 30 people over two floors. People living in the main house are generally more independent and require support with some daily living tasks such as personal care or support with their medicines management and the provision of meals. In addition there is a newer ground floor extension which provides a nine bedded unit for people living with more advanced dementia known as The Cottage. People living on this unit are more dependent and require support with most aspects of daily living and regular monitoring and supervision to ensure they are safe. Parking is available within the grounds. The home is not registered to provide nursing care but does provide a day care service. There were 37 people living in the home at the time of our inspection.

At the last inspection, the service was rated good overall. This inspection found that the service remained good.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

Improvements were needed to ensure the proper and safe use of medicines.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff were confident the registered manager would act upon any concerns they raised.

People had risk assessments and where risks had been identified, measures were in place which helped to ensure that the risk was minimised.

Safe recruitment practices were followed and there were sufficient numbers of staff deployed to meet people's needs.

Staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. Staff acted in accordance with the principles of the Mental Capacity Act 2005. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for.

Staff received training, supervision and an induction which ensured they had the skills and knowledge to support people appropriately.

People told us the food was tasty and that they were supported to have enough to eat and drink.

People were cared for by staff that were very kind and caring and with whom they had developed strong relationships. Staff were attentive, showed people kindness and patience and displayed a genuine interest in the people they supported. Staff delivered care in a compassionate manner and people were treated with dignity and respect.

Care plans contained the information needed to support staff to provide people's care in a manner that was responsive to their individual needs. People were supported to take part in a range of activities and make choices about how they spent their time.

People spoke positively about how well organised and managed the service was. The engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements.

There were systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate support.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service remained rated as requires improvement.

Improvements were still needed to ensure the proper and safe use of medicines.

Is the service effective?

Good

The service remained good.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service was now rated as good.

A registered manager was now in post. People, staff and relatives told us the registered manager was a good leader, approachable and accessible to staff who valued her support and guidance.

Woodlands House

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 took place over two days on 31 May and 1 June 2017. The inspection was unannounced. The inspection team consisted of one inspector and an expert by experience.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by managers to tell us about important issues and events which have happened within the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with nine people who used the service and seven relatives. We also spoke with the registered manager, three care workers and two activities staff. We reviewed the care records of four people in detail and the recruitment and induction records for four staff. We also reviewed the medicines administration records (MARs) for 16 people. Other records relating to the management of the service such as audits, meeting minutes and policies and procedures were also viewed. Following the inspection we received feedback from five health and social care professionals.

The last inspection of this service was in March 2015 when we rated the service overall good.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Woodlands House Care Home. One person said, "Its lovely here, yes I do feel safe". Another person said, "I feel safe when the staff help me to come out of my room". A third person said, "I always have my buzzer nearby, If I need something and the person who comes isn't sure how to help me or needs extra help, they will always go and find someone who can help". A relative said, "They give safe care and I feel that my parents needs are met". Another relative said, "There is always staff training…it makes us feel that [the person] is safe, we don't have to worry, they don't just employ anyone".

Some aspects of people's medicines could be managed more effectively. One person had not received their medicines as prescribed. The person had been prescribed a short course of a medicine to be taken four times a day. For six successive days the last daily dose had not been administered, as at the time of the medicines round, there had not been a sufficient gap since the previous dose was administered. However, staff had not thought to contact the GP to discuss whether it might be appropriate to review the times the medicine could be given. The date of opening had not been recorded on one person's eye drops. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. However, we found three examples where there were unexplained gaps in the MAR. A check indicated that the person had received their medicines, but the staff member had not signed the MAR to confirm they had administered this. Where people were prescribed topical creams, topical cream administration records (TMARs) were in place, but staff were not consistently recording when creams had been applied. Some of these issues had already been identified as an area of concern by the management team and additional measures had been put in place to prevent further occurrences, for example, staff were now swapping MARs at the end of their shifts so that checks could be made for missing signatures. The frequency of audits had also been increased to monitor this and the completion of other medicines records.

Other aspects of medicines management were well managed. People were supported to self-administer their medicines where able. Relevant risk assessments were in place to support this. We observed staff undertaking a medicines round. They assisted people with their medicines in a person centred manner such as offering them a drink of their choice or asking them if they would like some pain relief. They stayed with people until they had taken their medicines. Where people were prescribed 'as required' or PRN medicines to manage pain relief or behaviour which might challenge others, PRN protocols in place, although we did note that some of these would benefit from being more personalised. We discussed this with the registered manager who took action to address this.

Medicines were stored within locked trolleys or a designated medicines fridge, kept within locked rooms. The temperature records for both the room and medicines refrigerator were being monitored. We carried out a stock check of Controlled drugs. Controlled drugs (CD's) are medicines which are controlled under the Misuse of Drugs Act 1971 and which require special storage, recording and administration procedures. The CD register tallied with the medicines being stored in the CD safe. Staff administering medicines had received training and had a six monthly review of their competency to administer medicines safely. They were able to confidently describe the procedures they would follow in the event of a medicines error. Where

medicines errors had been made, staff were removed from administering medicines and were required to retake their medicines training.

Risks to people's wellbeing had been assessed. For example, people had room risk assessments, moving and handling and bed rails risk assessments. Nationally recognised tools were being used to monitor whether people were at risk of poor nutrition. Those seen were mostly up to date. Food and fluid charts were being used so that people's food intake could be monitored, however, it was not always evident what action had been taken when a person's actual fluid intake was below their target intake. The food charts for one person who was at risk of poor nutrition did not reflect that they were being offered regular snacks or fortified drinks in between meals. The registered manager told us this had already been identified as an area where improvements were needed. They told us the need to escalate concerns about people's food and fluid intake to the senior team would be reinforced so that remedial actions could be taken.

Where people were at risk of falls, we were able to see that they had for example, been referred to the falls prevention team. Alarm mats were used to alert staff that people vulnerable to falling were mobilising so that they could check on the person and offer support as necessary. We have recommended that the service also consider using a post falls protocol to monitor the person's wellbeing in the period following a fall.

People at risk of choking had been referred to relevant healthcare professionals for an assessment and their advice and recommendations were clearly displayed within the service and included in eating and drinking care plans. The staff we spoke with were well informed about people's risks and the measures in place to minimise these.

A range of environmental risk assessments had taken place. For example, assessments were in place regarding the use of showers, baths and the stairs. Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. Checks were made of the safety of electrical appliances, the call bell system, bed rails, hoists and slings and window restrictors. The lift was checked each quarter. Weekly and monthly checks were undertaken of fire safety within the service. A fire risk assessment had been completed in June 2016 the actions resulting from this had either been completed or were underway. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A legionella risk assessment had been completed and regular checks were made of the water safety within the service. A business continuity plan was in place and set out the arrangements for ensuring the service was maintained in light of foreseeable emergencies.

Staff employed to work at the home included the registered manager who was supported by two heads of care. Care was provided by a team of senior care workers and care workers. The home also employed a maintenance team, a chef, housekeeping staff and two activities co-ordinators who provided 56 hours of activities each week. During the day, the target staffing levels in the main house were one senior care worker and three care workers supported by a head of care. The Cottage was staffed by one senior and one care worker. At night there were four care workers. The home had a team of bank staff and the registered manager explained they were able to cover gaps in the rota. Agency staff had not been required for over a year. This helped to ensure that people were cared for by staff who knew them well. We reviewed a sample of the staffing rotas for the month prior to our inspection and found that the service had been staffed to the levels described above.

People told us they were satisfied with the staffing levels and most care workers told us there were usually sufficient numbers of staff to meet people's needs safely. One staff member said, "We all work really hard, buzzers are answered quickly, we help each other". Some concerns were expressed by staff about the

numbers of care workers deployed in The Cottage at busy times of the day. One staff member explained that it was not always possible to monitor the communal areas, as at times both staff members were required to manage people's support. We spoke with the registered manager about this, they said that if both staff working in the cottage were engaged in caring for a person, they were able to call over to the house for a third member of staff to come and cover them. They were confident that this arrangement ensured that people were being supervised by staff at all times. Throughout our inspection, we observed that staff were able to provide support to people in a timely manner and were able to carry out their role and responsibilities effectively.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. These measures helped to ensure that only suitable staff were employed to support people in their homes.

Staff had received training in safeguarding people from harm or abuse and had a good understanding of the signs of abuse and neglect. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. The registered manager explained that staff meetings and supervisions were used to reflect upon the importance of safeguarding people from harm. Staff were informed about the organisations whistleblowing policy and they were clear they could raise concerns with the registered manager but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

Good

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. A relative told us, "Yes the care my mum gets is safe, they explain how and why they are going to move her before they do it, they don't rush her, I feel confident in the staff's ability. I know that they go on training, they tell us what training they have had at the residents meetings". Another relative said, "We are happy with the care [the person] gets, we can see they are happier too and since being there they have even put on weight which is good to see as they weren't looking after themselves properly at home".

Relatives told us they had recommended the service to others. One relative said, "Wouldn't mind living here myself if I needed care…yes I would definitely recommend….hand on heart we couldn't have chosen a better place for mum, we recommended it to our friends and they have their relative here too…we are glad we found the place".

We observed that staff sought people's consent before providing care and people were encouraged and supported to make decisions about their care and support. For example, we heard staff saying to one person, "Come and have a look at the cereals and see which one you would prefer". At lunch staff supported people to make a choice between two juices by showing them the options. Information was available in care plans about the level of support people needed to make specific decisions.

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. Where there was doubt about a person's capacity to make specific decisions, staff had completed mental capacity assessments. For example, people had mental capacity assessments regarding their ability to be involved in decisions about their care and support, the use of bed rails and their safety were they to leave the home unaccompanied. Where it was determined a person did not have the mental capacity to make a specific decision a consultation had been undertaken to reach a shared decision about what was in the person's best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and were either authorised or waiting to be assessed by the local authority.

Woodlands House provided a clean and safe but comfortable and homely environment that was appropriate to people's needs and assisted them to remain as independent as possible. The home was nicely decorated and equipped with all of the necessary equipment needed to meet people's needs. Some of the people living at the home were living with dementia, and so aspects of the home had been designed

with their needs in mind. Pictures were displayed of each of the staff team and their role within the service along with information about planned activities and the organisations vision and values. All toilet doors were painted yellow and were clearly signed. All toilet seats were blue making them easier for people with cognitive or visual problems to see. People's rooms had an individualised sign decorated with pictures of their choice, helping them to identify their room. Their rooms were personalised to their own taste with photographs, pictures and items of their own furniture.

In addition to the large communal lounge, there was a smaller library, without a television, where people could spend some quiet time. The lounge and other areas of the home were decorated with age appropriate pictures. The kitchen was accessible and sometimes used by people to help prepare sandwiches for tea time. The gardens were well maintained and contained seating areas and lots of bird feeders which provided interest for people throughout the year. An ongoing improvement plan was in place. The library had just been refurbished and vegetable patches created. Plans were also in place to upgrade more ensuite bathrooms to include wet rooms.

New staff received a service based induction which involved shadowing more experienced staff, learning about the care philosophy within the home, people's needs, daily routines and key policies. As part of their induction staff were supported to complete the Care Certificate. This was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate.

Staff felt the training provided was adequate and helped them to provide effective care. The training was mostly completed online and included topics such as moving and handling, safeguarding people from harm, the Mental Capacity Act 2005, infection control, health and safety, fire safety, first aid and food hygiene. Additional training relevant to the needs of people using the service was also undertaken. For example, staff undertook online training in subjects such as dementia care and pressure area care. The chef had been booked on training on how to meet the needs of people who required modified diets. The registered manager had allocated staff members to become champions in certain areas such as infection control, care planning, end of life care and continence care. The champions were provided with opportunities to attend distance learning courses in the relevant subjects. There was evidence that staff were encouraged to undertake nationally recognised qualifications in health and social care and the organisation offered a leadership development programme to mentor and nurture staff taking on management roles.

Staff received supervision and an annual appraisal. All of the staff we spoke with told us they received adequate supervision and found this a useful and supportive process. They also told us the registered manager was always available to support and guide them in between formal sessions. Staff also had an annual appraisal which included feedback on their performance and a review of how they were working toward learning and development goals.

People told us the food provided was good and met their individual preferences. One person said, "The food is nice, I'm vegetarian, so they see to that". Another person said, "The food is nice, I have never had to change my choice, but I could if I wanted to". A third person said, "Lovely food, like a hotel". We reviewed the menu for the week of our inspection. This showed that people could have a variety of breakfast foods including a cooked breakfast. Lunch was a two course meal. The menus included a wide range of meals including traditional favourites such as roast dinner and fish and chips and lasagne. Supper was soup, sandwiches or other lite bite meals. Fresh fruit salad was available each day. We observed hot and cold drinks be served regularly throughout the day along with biscuits and homemade cakes. Each person had water jugs in their room.

We observed lunch-time in both the main dining room and in The Cottage. People using the dining room were sat at tables with clothes, cutlery, napkins and condiments. There were sufficient numbers of staff available to ensure that food was served promptly. People appeared to be enjoying the dining experience and chatted readily with one another and with the staff some of whom ate their lunch alongside people. Most people in the house were able to eat and drink independently, but staff were aware of those who might need a little extra encouragement and provided this where needed. For example, we observed that a carer had noticed one person had not eaten well. They asked the person if they were feeling alright or wanted an alternative.

The dining experience in the cottage was quieter. Two people ate their meal in the dining room, one person was in the lounge. Others were supported to eat and drink in their rooms. We observed staff supporting people to eat and drink in a kind and attentive manner. For example, one person was sleeping, the care worker gently stroked their face to wake them, saying, "Come on, let me see those blue eyes'. We heard another staff member praise a person for eating well and encouraging them to eat their vegetables. Staff explained to people what each element of the meal was gently spoke with them whilst assisting them to eat. We were advised that moulds had been purchased to enable pureed foods to be presented in a pleasant manner and to ensure that people continued to be able to taste the individual flavours of their meal.

People's weight was monitored regularly to assist in identifying whether they were at risk of malnutrition. Where people had significant amounts of weight this information was shared with the GP so that fortified diets could be offered.

Where necessary a range of healthcare professionals had been involved in planning and monitoring people's support to ensure this was delivered effectively. A local GP surgery visited once a fortnight to review people who were unwell or about whom the service had concerns such as weight loss, increased confusion or to discuss falls. Records were maintained of the consultations and any recommendations made appeared to have been actioned. People were also supported to see other healthcare professionals such as the community nursing team, opticians and chiropodists. The service had also arranged for some people to see a private speech and language therapist to assess their dietary requirements. Most people had a hospital transfer form. This form documented key information about the person's physical health, allergies and whether they had an advanced decision in relation to their end of life care. This helped to ensure that the transfer of care was managed in an effective manner.

Good

Is the service caring?

Our findings

People told us they were cared for by staff who were kind and caring. One person told us staff were, "Very kind and patient". Another said, "They [the staff] are all kind and caring, they will do anything for you, I was a bit apprehensive when I first moved in, but I have settled in, its just like home, I do what I want…I couldn't be happier, we found the perfect place, I've not once regretted it…they are the best staff ever, like a family, I can't think of anything I would change". Another person told us, "Sometimes I get lonely, the staff are very good, if I'm feeling down, they will stay and have a chat with me and try to lift me up. If I'm crying they won't leave me, they will stay and try and sort out what's bothering me". A relative said, "Its homely here, like home from home". Another told us, "It's just like being in your own home".

Our observations indicated that staff showed people kindness and patience. For example, we observed that throughout our inspection, one person was frequently anxious and sought constant reassurance from the staff. Each time, staff responded to the person in an attentive manner, holding their hand, reassuring them in a kind and caring manner. At no point did staff dismiss the person's anxieties; each repeated interaction was person centred and comforting, enabling the person, for a time, to become a little more settled.

Staff spoke fondly about the people they supported and it was clear that they knew them well and had developed a meaningful relationship with each person. We saw a considerable number of warm and friendly exchanges between staff and people and the atmosphere was good natured and sociable. For example, we saw a staff member approach one person and take their hand, greeting them. The person turned and hugged the care worker who reciprocated. It was clear the person valued this and gained great pleasure from the interaction. We observed staff dancing with people, they told us, '[the person] used to be a dance teacher'". Again the person was enjoying themselves. We heard a person tell a staff member, "I love you", the staff member replied cheerfully, "Love you more". We heard staff say to one person, "Would you like a pillow behind your back" and to another, "That's a pretty jumper you are wearing". People looked relaxed and happy in the company of the staff who throughout our visit appeared attentive and happy in their work. Staff provided care in a compassionate manner. For example, we were told how staff had bought new, shorter, tops for one person so that they could assist them, to get dressed without hurting their shoulders. A staff member said, "I love the residents, it's not like coming to work, it's like coming home".

Staff had organised events that had a positive impact on people's lives. For example, staff had recently organised an 'Oscars Night'. There had been a red carpet and champagne. The residents and staff had voted for the kindest, funniest, best dressed and the person with the best hair. Those winning the awards had received chocolates and had been given the opportunity to make a speech. The registered manager told us how the event had had a positive effect on one person who after winning an award had become more confident and was now coming down to join the others for lunch every day. A relative told us, "Everyone got an Oscar and mums was for singing, it was a lovely night". Other relatives told us how the service had supported them to celebrate their family member's birthdays. One said, "The staff are lovely and friendly, they provided a cake for mums recent birthday and came in to her room to sing happy birthday, she loves music and they will leave music on in her room, she used to sing and likes that, it's the little touches like that that mean a lot to her and to us. They treat her like an individual".

People were supported to express their views and be actively involved in making decisions about their care. For example, staff had made personalised picture sticks for one person with limited communication. The sticks had pictures of the person's favoured foods on them and activities she might want to take part in such as attending the hairdresser. The person was thrilled with the sticks which supported her to make her wishes known to staff. People told us they could choose how to spend their time, for example, one person said, "I like it that I can have my breakfast when I want". Another person said, "I can join in with the activities if I want to, they don't push it, sometimes I prefer to read quietly in my room". Relatives also felt involved in decisions about their family members care. A relative told us, "When [person] had to move from the main house to the more dependent area, the whole family felt involved in why the decision needed to be considered, then actioned, we all had a say in and agreed the decision".

Staff supported people in a way that maintained their independence. For example, people were encouraged to get involved in daily chores such as laying the tables and helping with pushing the tea trolley. Where appropriate people had access to adapted cutlery and crockery which enabled them to eat without assistance. For example, staff had bought one person had a lightweight cup and saucer as the usual ones were too heavy for her to lift.

Upon admission to the home people were given a service user guide which included a 'Residents Charter' which stated people had the right to be treated with respect, kindness and to have their confidentiality respected. Everyone we spoke with told us staff followed these principles and that their dignity and privacy was respected. Staff spoke to us about how important it was to protect people's privacy and dignity and were able to give examples of how they maintained peoples dignity by ensuring that curtain and doors were kept closed when people were receiving personal care. We saw staff knocked on people's doors before entering and addressed them by their chosen names. We observed a care worker discreetly use a tissue to assist one person to wipe their face following their meal.

The registered manager explained that the service was starting to implement the Gold Standards Framework (GSF). The GSF is an accredited training programme supporting staff to provide the very best care to people approaching the end of their life. It supports staff to work effectively with GPs and other health care professionals to achieve better advance care planning, develop staff skills and knowledge and allow people to die in a setting of their choice. Key staff were attending training for this programme and would be acting as leads for this within the service. The registered manager had also put together a training pack for end of life care that was being shared across the organisation. People and their relatives had been involved in developing end of life care plans. These gave the person, as far as possible the opportunity to discuss their thoughts and fears about their final days, but also about how they would like their care to be managed at this time. For example, we saw one person wanted soft music playing, the windows open but the lights switched on. Another person wanted joyful music, to be able to hear the voices of staff and to be warm and cosy. The plans also recorded the person's wishes about what they wanted to happen following their death. People were supported to follow their spiritual beliefs. Every other week a Christian communion service held and clergy from other denominations also visited.

Relatives and visitors were free to visit at any time and told us they were warmly welcomed by staff. One relative told us, "The girls are very good, we are made to feel very welcome, there are always lots of cups of coffee". Relatives praised the homely nature of the service. One relative said, "They had a garden party here in the summer, which is great, families come and grandchildren, a lovely atmosphere, family is really included at this home". A newsletter was drafted each month to keep people and their relatives up to date with events within the service, such as the plans to work towards achieving the Gold Standards Framework.

Through fundraising events such as the summer fun days and fetes, the organisation raised money to

support the work of a charity for current and retired care workers who were struggling financially perhaps due to being unable to work because of an injury. This evidenced that the organisation valued the work of care workers and the contribution they made to the provision of good quality care.

Good

Is the service responsive?

Our findings

People and their relatives were positive when they spoke of the responsiveness of staff at the service. All of the feedback we received was positive when people were asked if their care needs were met. For example, one person said, "If I had a headache, I could ask for painkillers easily and they would get them". Another person said, "I like to go out for some fresh air and they take me out into the garden". A third person said, "Joining in with the activities depends upon the day and what is going on, they [staff] will try to find something I like to do". A relative told us, "Staff know what [the person] wants, they know they can ask for what they want too, their preferences are catered for, they had a phase of wanting a particular drink at night time and the staff got it for them".

People's needs were assessed before they moved into the home. This helped to ensure staff had key information about the person and helped to ensure they could meet their needs. Care plans included specific, individual information, about the person, their needs and their life before coming to live at the service. For example, people had a 'my preferred routines' which described their preferred time to get up in the morning to go to bed. Care plans included personal hygiene plans, continence plans, medicines plans and end of life plans. Eating and drinking plans were informed by people's wishes, for example, one plan recorded where the person liked to sit to eat their meals, the favoured meals and that they did not like milk in their tea. Where necessary, people had condition specific care plans which described how staff might best support the person with this need. For example we saw one person had a dementia care plan and another had a behaviour care plan which provided basic information for staff on how they might best address or de-escalate behaviours of concern. This enabled staff to have a good knowledge and understanding of the people they were supporting and helped to ensure people received care and support which was responsive to their needs.

During each shift staff maintained records which noted the care that had been provided to each person, how they had eaten and what activities they had been involved in. A handover was held at each shift change and for part time staff or those that had been on leave, a weekly summary of the handovers was produced which helped to ensure they were kept up to date with people's changing needs. People told us that staff recognised if they were feeling unwell and took action in response to this. This was confirmed by relatives, for example, one relative told us, "The staff are aware that [person] is prone to [urine infections] and if this happens, that they can become a bit more confused. If this happens they will check to see if they have got an urine infection so it can be treated quickly". Another relative said, "If my relative is poorly or there have been changes, the staff will ring to let us know what's going on". We did note that records did not always fully reflect what action had been taken in response to staff identifying that people had skin damage. We discussed this with the registered manager who advised that changes would be made to the body maps used to ensure these reflected what action had been taken and included a daily evaluation of the skin damage until it had healed.

There was evidence that the care plans seen had been reviewed on a monthly basis and were generally up to date and reflected people's current needs. Every three months, more in depth reviews were held with the person and their family members if appropriate. These were led by the person's key worker. Key workers

worked more closely with the person so that they became very familiar with their needs and wishes. Photographs of people's key worker were displayed in their room. A relative told us, "I know who mums key worker is and I can always discuss any concerns with them". Another said, "Yes I am kept informed, I come in and go through the care plan and discuss how mum is getting on".

All of the people and relatives we spoke with were positive about the quality and quantity of the activities. There were two designated activities staff who were responsible for leading a variety of activities and co-ordinating a range of external entertainers who visited the home. Internal activities included basketball, flower arranging, bean bag target practice and a Eurovision sweepstake. People were supported to have garden walks in small groups and take part in a community coffee mornings such as one which had had a guest speaker talking about the 'Great National Parks and Wildlife'. We observed staff doing quizzes and playing games with people. Fiddle cushions and sensory beans were available for staff to use with people living with dementia to help alleviate their anxiety and restlessness. The timing of activities provision had been altered to cover early evenings as staff had recognised that this was a time when some people could become restless or unsettled. Where people chose to spend time in their room, the activities staff aimed to spend one to one time with them at least twice a week to ensure they were not at risk of becoming isolated. Activities staff told us they were developing a personal activity plan for each person which would assist them to further tailor the activities to people's interests and hobbies.

The registered manager demonstrated a positive attitude to seeking and acting on feedback and people. Resident and relative meetings took place. One relative told us, "We attend resident meetings every month and we get the minutes from these via email even if we are away". It was clear from minutes of meetings that people's views and those of their family members were valued and acted upon. For example, more salads had been added to the menu and parking arrangements had been reviewed to ensure that visiting relatives were able to park easily. One relative said, "They are open to ideas and they give us feedback". Another said, "We feel listened to if we have any concerns. We had a concerns regarding cleaning, we discussed it and it was rectified". People were also provided with annual opportunities to give formal feedback about the service and the care they received. The most recent surveys had just been sent to people, once returned, they would be analysed and an action plan developed to address any areas for improvement. Information about how to make a complaint was freely available within the service and within the service user guide. The complaints received had been appropriately documented, investigated and acted upon.

Good

Is the service well-led?

Our findings

People spoke positively about the registered manger and about how well organised and managed the service was. This was echoed by relatives. One relative said, "Yes they seem a strong leader…they have a good rapport with staff and residents… [the registered manager] is my first port of call, she will sort it out straight away, if I send an email, she gets back to me that day". Another relative said, "The manager is visible….she has an open door policy, she is very approachable".

The staff we spoke with were positive about the leadership of the service and felt well supported in their roles. One staff member told us, "[The registered manager] is knowledgeable and very approachable, If I have ever been down, I always been able to talk to her, if ever there is a problem, she sorts it straight away". Another staff member said, "They are definitely a good leader, they do really well". Staff meetings were held on a regular basis and were used to communicate key messages about matters such as people's care needs and staffing issues. The registered manager told us that the results of the recent staff survey had shown that some staff did not always feel well supported and reported low morale. This was not in keeping with our findings during the inspection, but to address the concerns, the registered manager had met with staff to seek their views about what more could be done to support and develop them. Measures such as additional training were being put in place.

The service had systems in place to report, investigate and learn from incidents and accidents, for example, we saw that following a medicines error, the member of staff involved had been suspended from administering medicines, a reflective supervision had taken place and a competency assessment undertaken. Each month the registered manager completed an accident analysis to identify any trends or patterns so that remedial actions could be taken to reduce the risks of similar accidents happening again. This had highlighted that one person had suffered a number of falls from their bed. To limit the risk of further harm, the service had provided a low profiling bed. The registered manager reviewed the number of hospital admissions that had taken place and the reasons for these. This was in part to help ensure that where people had expressed a wish to receive their end of life care at the home, that this was being supported.

There were systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving safe and effective care and support. An external company undertook a health and safety audit of the premises. Three or four care plans were audited each month and infection control and medicines audits were also undertaken. Where the audits had highlighted that improvements could be made, an action plan had been developed. The registered manager acknowledged that further improvements were still needed with regards to medicine management and the completion of some records, to address this; they had increased the frequency with which they were completing audits in these areas, until they could be confident that the improvements had been made, embedded and sustained. Senior staff undertook direct observations of staff to ensure that areas such as personal care and support with meals was being provided in an effective and person centred manner.

The registered manager understood their role and responsibilities. They had notified the Care Quality Commission (CQC) about important events, which the provider is required to send us by law. This enabled

us to effectively monitor the service or identify concerns.

The registered manager had a good understanding of the organisations values which were care, comfort and companionship. They told us that it was important to them that the home was family orientated and that care was delivered with compassion and kindness. They said, "Hugs are readily available here, staff dance with people, [person] likes staff to stroke her hair, they do this…I don't think they [people using the service] see the staff as staff". They explained that it was important to them to continue to nurture an environment where people and their relatives cared about one another. They described how relatives readily chatted with other residents, played board games with them or took them out into the garden. We observed a person responding patiently, when a person living with dementia came into their room by mistake. They offered them chocolates and chatted with them in a friendly manner.

The registered manager had ensured the service maintained strong links with the local community. The service held fun days to which the local community were invited. Local children had visited for Easter egg hunts and for pumpkin carving at Halloween. The organisation sponsored the local under eights football club and people were supported to go and watch some of the matches. When able people were supported to visit the local supermarket but a small mobile shop was also available on site. The registered manager was in discussion with local primary schools regarding people visiting to hear the children read. This all helped to ensure that people remained a valued part of their local community.

The registered manager had a good insight into the strengths of the service and the ongoing challenges such as recruitment. They told us they were proud of the service and of the staff who worked hard to ensure that "People lived happy, purposeful lives and had the very best end of life care". They were committed to their own personal development and the organisation were supporting them to develop their leadership and business administration skills. They told us, "I have learnt about what 'good' care looks like and how we can push ourselves to achieve great things".