Woodland Healthcare Limited

Woodland Park

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8 and 9 February 2018 and the first day was unannounced. At our last inspection in August 2016 we found the provider was in breach of regulation because accurate, complete and contemporaneous records were not in place for each person living at the home. The home was rated as Requires Improvement at that time. Following this inspection the registered manager sent in an action plan stating what action would be taken to address the breach of the regulations. At this inspection we found sufficient action had not been taken in relation to the concerns identified at the previous inspection. We also identified new areas of concern.

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

Woodland Park provides 24 hour nursing care, personal care and intermediate care for up to 31 older people in one adapted building. There were 23 people living at the home at the time of our inspection.

There was a registered manager in post who worked across two registered services and spent half their time at each. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk assessment tools were used to identify common risks such as those relating to falls, skin integrity and medication. People who were at risk of developing pressure ulcers had pressure relieving equipment in place such as pressure relieving air mattresses and cushions. However, some risks to people's health and wellbeing were not always identified in people's care plans, and risk management plans were not always in place to instruct staff on how they should care for people safely.

Some risk assessments and care plans contained detailed guidance; however, records did not always show that care had been delivered as it should. For example, where people required regular repositioning, records did not demonstrate this had taken place and quality assurance systems had not identified this.

The environment was not always safe. Three exit doors at the side and rear of the property were unlocked. One door did not have a lock and opened by turning the handle from both inside and outside of the property. The door was not alarmed. This meant anyone could gain access to the home and people's bedrooms, unnoticed and unchallenged by staff. This put people's safety, their belongings and the security of the building at risk.

An effective robust system was not in place to assess and monitor the quality of the service. Quality assurance systems had failed to identify the issues we found during our inspection to help drive and make

all of the necessary improvements.

We heard bells ringing during the inspection and these were responded to effectively. We received mixed feedback from people and their relatives in relation to staffing levels. One person told us, "I think they're understaffed. I've been here hearing people ring for a while." Another person told us, "I use my bell when I need it, and they come." Relatives we spoke with also felt that people waited a long time for attention. However, during the inspection we saw people's needs were usually met quickly.

We looked at how medicines were managed within the home and observed how medicines were administered. During the inspection we observed administration practice that was not considered best practice nor did it follow the provider's own medicine policy. We made a recommendation to the provider about this.

Other aspects of medicine administration, documentation and storage were managed safely.

At the last inspection in August 2016 we found improvement was needed in relation to supporting people to maintain their social activities and interests. During this inspection although there had been some improvement with the employment of an activities co-ordinator, people and their relatives felt further improvement was needed. One person said, "There is always something going on." Other people and relatives were not so positive about the activities. One relative told us that activities seemed very few and far between. We saw there was a programme of activities which included sing-a-longs, bingo, arts and crafts, reading and movie afternoons. People were also offered one-to-one activities tailored to their interests.

Most people we spoke with told us the 'girls' were very kind and did their best. However, two people commented that some members of staff did not speak to them in a kind way. We brought this to the attention of the registered manager. We observed positive interactions between staff and people and staff engaged in conversation with people throughout the day. We saw staff were cheerful and friendly, and people appeared to be very comfortable with all the staff around them. People told us staff respected their privacy and dignity, promoted their independence and always gave them choices.

We received mixed views about the food. Some people told us they really enjoyed the food and were looking forward to lunch as roast beef was on the menu. However, other comments were not so positive. People's nutritional needs were assessed and they received a choice of meals and drinks. Where people needed support to eat and drink enough to keep them healthy, staff provided assistance. People had access to other healthcare professionals that provided treatment, advice and guidance to support their health needs.

People told us they felt safe living at Woodland Park. One person told us, "I feel very safe here as there's always somebody around." People were protected from the risk of abuse because staff understood how to keep people safe. Safeguarding procedures were in place to help protect people from harm and staff understood their responsibilities to do so and to report any concerns.

We looked at recruitment processes and found that staff had been recruited safely. Staff told us they were well supported in their role and received appropriate training and professional development. Staff attended mandatory training in a range of subjects and also had the opportunity to attend other training courses to ensure staff were able to meet the specific care needs of the people who lived in the home.

Principles of the Mental Capacity Act (MCA) 2005 legislation were being followed and Deprivation of Liberty Safeguards (DoLS) applications were completed in line with current legislation. Staff showed a basic knowledge and understanding of both MCA and DoLS. Best interest decisions were being made

appropriately. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People's needs and choices were assessed and their care provided in line with their wishes, preference and desired outcomes.

There were arrangements in place for staff to monitor and take action when people experienced accidents or incidents. Accidents and incidents were analysed in a way which enabled trends to be identified and action could be taken to reduce risks.

We found two breaches in 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.

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 was not always safe.

Risks to people health, safety, and well-being were not always being effectively assessed, managed or mitigated.

The environment was not always safe. External doors were not always secured.

People received their medicines as prescribed and medicines were stored safely.

Staffing levels meant that staff were available when people needed them. The systems for the safe recruitment of staff were robust.

People were protected from the risk of abuse, as staff understood the signs of abuse and how to report concerns.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet the needs of the people who used the service.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

The service was working within the principles of the Mental Capacity Act 2005.

People were supported to maintain good health and had access to appropriate services, which ensured they received on-going healthcare support.

Is the service caring?

Good

The service was caring.

Mostly people were treated with kindness and respect and their privacy and independence was promoted and respected.

However, some people found some staff rude.

People lived in a home that was relaxed and welcoming and were supported to receive visitors whenever they liked.

People were involved in the planning of their care and were offered choices in how they wished their needs to be met.

Is the service responsive?

Good

The service was responsive.

People were supported to engage in activities of their choice. However, people felt that activities could be improved further.

People received personalised care that was responsive to their needs.

People told us their choices were respected.

People had information on how to make complaints.

People were supported to plan and make choices about end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Governance and quality assurance systems in place to assess and monitor the quality and safety of care and services provided were not always effective.

There was an open, transparent culture and staff felt supported by the registered manager. People were supported by staff who were happy in their work.

People and their relatives were asked about their views of the service through surveys and residents meetings to support quality improvements.

Woodland Park

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection; it took place on the 8 and 9 February 2018 and the first day was unannounced.

The inspection team consisted of one adult social care inspector and an expert-by-experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care home.

Before the inspection the registered manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. Before the inspection we spoke with the local authority Quality Assurance Improvement Team and the Adult Safeguarding Team.

We spent time in the communal areas of the home to observe how staff supported and responded to people. We spent time carrying out a short observational framework for inspection (SOFI) observation. SOFI is a specific way of observing care to help us understand the experiences of people who could not communicate verbally with us in any detail about their care.

During the inspection, we spoke with twelve people who lived at the home and five visiting relatives. In addition, we spoke with the registered manager, deputy manager, two registered nurses, two care staff, the activity co-ordinator and catering staff.

We reviewed three staff files, medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records

and surveys undertaken by the home. We also looked at the menus and activity plans. We looked at nine people's individual records, these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

Requires Improvement

Is the service safe?

Our findings

At the last comprehensive inspection in August 2016 we identified that the service was not meeting Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk assessments and care plans did not always reflect people's up to date care needs and it was not possible to tell from records or charts whether or not care had been provided in line with people's care plans. Records did not demonstrate whether there was registered nurse oversight into people's essential care interventions.

In their action plan the provider had told us they would overhaul record keeping with regards to care, risk management and link to care plans. They would carry out regular care plan audits to ensure improved record keeping and safer care. At this inspection we found sufficient action had not been taken to address concerns or led to the improvement required.

Some risks to people's safety and well-being were assessed and care plans guided staff on how to meet people's care needs and manage risks. However, records did not always show that care had been delivered as it should to mitigate the risks. For example, one person had a significant risk of developing pressure ulcers. Risk assessments had identified the need for regular repositioning. Their care plan said they needed staff to reposition them two to three hourly. Records did not demonstrate this had taken place or enable staff to accurately monitor the person's care. The person had hourly checking and repositioning charts for staff to record when they had attended the person and what position they had moved them to. However, the recording charts in the person's records did not have a date on them which meant it was not clear what day they referred to. Staff told us the charts we looked at were from the previous two days prior to the inspection. We saw from these charts staff had recorded hourly checks but on each occasion had recorded that the person was positioned on their back. This indicated the person had not had their position changed as required.

We brought this to the attention of the registered manager who agreed with us that it appeared from records that people had not received the care needed and as documented in their care plan. They told us records we looked at were old charts which did not make it clear that staff were required to record how they had repositioned people. The registered manager held a group supervision to discuss the concerns and remind staff to record when they repositioned people.

Where people were living with long term health conditions, such as, diabetes, records did not always identify how they were to be supported to reduce any risks and maintain their safety. For example, one person was living with diabetes and was having their blood glucose monitored by staff three times a week. Their 'safety' support plan instructed staff to 'follow risk assessment guidelines in the event of hypo and hyper'. However, there was no specific care plan or risk assessment in their records. There was no guidance on what action staff should take if their blood glucose was too high or too low. There was minimal information to guide staff about dietary needs. There was no information about the necessity of regular diabetic checks, such as specialist foot and eye care services in order to maintain the person's health. This meant that people living with diabetes could be at risk of not receiving the specialist care they needed.

Similarly, there were no risk assessments or care plans in place for people that were taking a blood thinning medicine. These medicines increase the risk of excessive internal and external bleeding following an injury. There was no information available for staff about people's risk of bleeding and there were no details for staff of what action to take if they suffered an injury.

This meant people may be at risk of harm because care records did not contain sufficient information and guidance to manage the risk.

While there were no detailed management plans for particular risks, the impact for people was minimised because staff had a good knowledge of their risks and how they could be managed. Staff told us they knew how to care for people living with these health conditions, as they had been trained to do so. The registered nurses told us they were aware of the risks associated with blood thinning medicines. We saw that where people required monitoring, such as; blood glucose levels, this was happening. We spoke to the deputy manager about the lack of guidance for staff in the care plans and they assured us they would address this.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although not all risks had been documented appropriately, other risk assessments had been undertaken to enable people to retain independence and make their own choices, whilst minimising risk. Risk assessment tools were used to identify common risks such as those relating to falls, skin integrity and medication. Additional assessments of specific risks took place when this was relevant. People who were at risk of developing pressure ulcers had pressure relieving equipment in place such as pressure relieving air mattresses and cushions. We checked mattress settings for three people and found two mattresses that were set correctly for people's weight. However, we found one person's pressure mattress was not set correctly for the person's weight. These types of mattresses must be set at the correct pressure in order to reduce the risk of skin damage. We spoke to the registered manager about this.

Despite the pressure mattress being incorrectly set, there was no evidence the person had been adversely affected by the incorrect setting, or had developed pressure ulcers due to lack of care.

The environment was not always safe. Three exit doors to the side and rear of the property were unlocked. One door located at the end of a quiet corridor with three bedrooms, opened out to the front of the property. The door did not have a lock and opened by turning the handle from both inside and outside of the property. The door was not alarmed. Some people at the home were living with dementia and may not be safe to leave the home alone. People could leave through these unsecured doors without staff noticing which would put them at risk. We saw that any person could gain access to the home and people's bedrooms, unnoticed and unchallenged by staff. This put people's safety, their belongings and the security of the building at risk.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014.

We brought this to the attention of the registered manager and asked them to act immediately to secure the doors. The registered manager immediately arranged for a bolt lock to be fitted to the door that did not have a lock. However, we saw that this did not fit well. We spoke with the registered manager who told us they would look into fitting a more secure fire door.

We looked at how medicines were managed within the home and observed how medicines were

administered. During the inspection we observed administration practice by a registered nurse that was not considered best practice nor did it follow the provider's own medicine policy.

We recommend the provider monitor the compliance of staff administering medicines in accordance with the policy.

Other aspects of medicine administration were managed safely. Medicines administration records had been completed and if medicines were not given for any reason, this was recorded appropriately. Where people had been prescribed creams or ointments, records showed these had been applied as prescribed. Some people had been prescribed 'as required' (PRN) medicines protocols were in place to guide staff as to when the medicine may be required. We looked at records for residents who received their medicines covertly, hidden in food or drink. There was documentation showing this had been agreed as being in their best interests. For medicines that staff administered as a patch, a system was in place for recording the site of application. This is necessary because the application site needs to be rotated to prevent side effects.

Medicines were stored safely in a locked room or in locked medicine trolley. Temperatures were being recorded daily in the medicines room and fridge. However, the temperature of the first floor area where the medicine trolley was being stored was not monitored and recorded daily to ensure they were within safe ranges. If medicines are not stored at the right temperature, it can affect how they work. We looked at a sample of people's medicine administration records and checked them against the stock. The stock record for one medicine, that required additional controls, was incorrect. Records showed a zero balance when there were two medicines in stock. Other medicine stock records were correct.

People told us that they felt safe and secure living at Woodland Park. Comments included, "I feel very safe here as there's always somebody around", " I do feel safe, and you can talk to anybody, it's like a social club" and "Oh God yes, it's safe. I couldn't cope at home on my own."

People were protected from the risk of abuse because staff understood how to identify possible abuse, and were clear in how they would report this. Staff told us they had received safeguarding training and they appeared confident in following relevant procedures that would keep people safe. Staff members also appeared confident in being able to raise concerns outside of the organisation if they thought that the matter was not being addressed effectively.

During the inspection we saw people's needs were usually met quickly. We heard bells ringing during the inspection and these were responded to effectively.

We received mixed feedback from people and their relatives in relation to staffing levels. One person told us, "I think they're understaffed. I've been here hearing people ring for a while." Another person told us, "That buzzer there….you push it and push it till the cows come home, but cows come home much faster." In contrast, one person said "I use my bell when I need it, and they come." Relatives we spoke with also felt that people waited a long time for attention.

We spoke to the deputy manager about staffing levels. They told us they reviewed people's needs regularly and used this information to complete a dependency tool. This helped ensure there were sufficient staff planned to be on duty to meet people's needs. The registered manager told us staffing levels were currently being affected by sickness. During this time the management team were available and worked alongside staff to provide care. They also told us they had an on-going programme of recruitment and had looked at sourcing suitable staff with the desired skills, from a local college.

Staffing levels at the time of the inspection were the registered manager, deputy manager, a registered nurse on duty and four members of care staff. There were a range of ancillary staff including housekeepers, chefs and a maintenance worker. At night time there were two care staff and one registered nurse

People were protected from being cared for by unsuitable staff because robust recruitment was in place. These records showed that new staff had completed an application form, undergone an interview process and had their identification checked. The registered manager also arranged for a Disclosure and Barring Service (DBS) check and for references showing the applicants conduct in previous employment. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for. Nurses' registration status was also checked to ensure that this was still valid. These recruitment processes helped to ensure that new staff were suitable to work with people living at the home.

We did not see any behaviour that may challenge others during our inspection. However, some people did require attention and reassurance from staff. We observed staff used appropriate distraction techniques to help improve people's well-being and to support people safely and effectively.

We observed moving and handling practices being completed safely and confidently by care staff. People told us they felt safe while staff were assisting them, for example, when using a hoist. Staff spoke reassuringly to them throughout the process and were unhurried in their approach.

Records showed accidents and incidents were recorded and reported. Appropriate actions were taken such as first aid being applied and referrals being made to other health care professionals. Accidents and incidents were analysed in a way which enabled trends to be identified and action could be taken to reduce risks. For example, the falls audit identified an increase in the amount of falls happening in the late afternoon. This prompted the deputy manager to look at staffing levels which led to an increase of care staff from three to four in the afternoon.

The environment at the home was clean and well maintained. We saw records and certificates that showed appropriate audits and safety checks had taken place. Each person had a personal emergency evacuation plan (PEEP), which contained details that may be needed to keep a person safe in the event of an emergency. We saw that staff used personal protective equipment to promote infection control, for example disposable aprons and gloves when assisting people with personal care.

Good

Is the service effective?

Our findings

People were looked after by staff that received the necessary training and support to carry out their roles. There was a comprehensive staff training programme in place and staff received updates were needed. Where people had specific needs specialist training was arranged such as pressure area care, death and dying and caring for people living with dementia. Other training included equality and diversity, food safety, health and safety, moving and transferring and first aid. The nursing staff told us they received training and support to maintain their professional registration with the Nursing and Midwifery Council.

Staff new to the home undertook induction training. This included time to familiarise themselves with procedures and policies, undertake essential training and meet people living at the home. They also worked alongside experienced staff. Staff new to care were supported to undertake the Care Certificate. The certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support.

Staff had received regular supervision and appraisal. During supervision, staff had the opportunity to sit down in a one-to-one session with their line manager to talk about their job role and discuss any issues. Staff also benefitted from group supervisions where topics related to care were discussed, such as, diabetes care, pressure area care and effective communication.

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. The home held an appropriate MCA policy and staff had been provided with training in this legislation.

Some people living at Woodland Park had the mental capacity to be able to consent to live in the home and receive care. However, some people were living with dementia which affected their ability to make decisions about their care and support. We saw examples of decision specific mental capacity assessments relating to using bedrails on people's beds, personal care and taking medication. There were clear procedures in place for staff to follow when people were not able to make decisions about their care or treatment. For example, where a person had been refusing to take their medicines but did not have the capacity to understand the consequences to their health if they did not take them, a best interests meeting involving staff, their GP and family members had been held to discuss whether it was in the person's best interests to have the medicine hidden in their food.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made applications to the local authority to deprive six people of their liberty in order to keep them safe. Due to the large number of applications being processed by the local authority only two applications had been authorised at the time

of the inspection.

People were asked for their consent by staff throughout the day when care and support was offered. Staff asked people were they wanted to spend their time and what they wanted to do. One staff member told us, "I always assume they have capacity to make decisions unless proven otherwise. I always give them choices and they choose what they do."

We received mixed views about the food. Some people told us they really enjoyed the food and were looking forward to lunch as roast beef was on the menu. However, other comments were not so positive, "Well, there's loads of it, not necessarily wonderful" and "Yes, you get a menu to choose from the night before. Sometimes it's not so good."

We observed people's lunchtime experience. People chose were they wanted to eat their meals with some people choosing to eat in the lounge, dining room or their rooms. We observed staff supporting people with eating where needed and encouraged independence where people were more able. Staff were patient and reassuring and ensured people ate as much of their meal as they were able to. People were offered a choice of meals and throughout the inspection we saw people were regularly being offered tea and coffee, or fruit juices and water.

People's nutritional needs were assessed and weights were monitored. Staff regularly monitored food and drink intake to ensure people received enough nutrients in the day. Where people lost weight care plans showed that advice was sought from GP's and dieticians and people were given high calorie foods and supplements. When people had been assessed as having a high risk of choking, advice was sought from SALT (speech and language therapist) and this guidance was documented within the care plans. The chef had been provided with detailed guidance on people's preferences, nutritional needs, allergies and dietary requirements.

People were able to see a range of health care services when needed, and had regular contact with dentists, opticians, chiropodists and GPs. People's care plan contained details of their appointments. Where changes to people's health or wellbeing were identified, records showed staff had made referrals to relevant healthcare professionals in a timely manner. For instance, one person's records showed that staff had sought guidance from the Tissue Viability team where they had concerns about the condition of the person's skin integrity.

During our inspection, we looked around the home to see how the home was decorated and furnished and to check if it was suitably adapted for the people living there. The building was well maintained. It was decorated and furnished in a modern, bright and homely way. Bedrooms we viewed were comfortable and personalised with photographs, furniture and other personal effects. People could enjoy spending time in a comfortable dining area and lounge. Outside space was limited but this was not raised as a concern by any of the people we spoke with.

Good

Is the service caring?

Our findings

We asked people about the care and support they received from staff at Woodland Park. We wanted to know if people had positive caring experiences and were treated with kindness, respect and compassion. We received mixed feedback. Most people we spoke with told us the 'girls' were very kind and did their best. Comments included, "[Name] is lovely, she's a nice girl", "It's like heaven here" and "[Name] she doesn't talk at you. She's above and beyond she is."

However, two people told us the attitude of one or two members of staff was not very caring or kind. They went on to say, "[Name] is quite rude and is on her best behaviour today, probably because you're here." Another person said, "I get a lot of back-chat and I don't want to be talked to like that. I don't need that."

We spoke to the registered manager and deputy manager about the negative comments. They told us they would address these individually and during group supervisions.

We observed positive interactions between staff and people and staff engaged in conversation with people throughout the day. We saw staff were cheerful and friendly, and people appeared to be very comfortable with all the staff around them. Staff spoke warmly about the people they supported and provided care for and said they enjoyed working at the home. One member of staff said, "I make sure people are comfortable and happy, I treat people like I would my own mum." Another member of staff told us, "I really like it here, it's a lovely home and we work well together. I love looking after people."

The deputy manager and staff showed genuine concern for people's wellbeing. It was evident from discussions that all staff knew people well, including their personal history preferences, likes and dislikes and had used this knowledge to form strong therapeutic relationships. We found that staff worked hard to ensure people received care and support that suited their needs.

People's privacy and dignity were respected. Staff asked people beforehand for their consent to enter a room or provide any care and doors were always kept closed when personal care was being offered. We saw staff ensuring one person had a blanket over their legs to preserve their dignity while they were being assisted to move using a hoist. We saw staff were discreet when discussing people's personal care needs. When staff were speaking with people they respected people's personal conversations and views. People's personal information and personal files were stored securely. Staff and the managers were aware of the need to maintain confidentiality and store information securely. The home had a member of staff who was an appointed 'dignity champion' and the topic was discussed through staff meetings to ensure staff remained well informed.

People's day-to-day choices were respected. We saw staff offered people choices throughout the day such as where they chose to sit and what they would like to eat. Staff we spoke with knew people well and knew their likes and dislikes. One staff member told us, "Even though I know people I always ask them what they want." This demonstrated that people's choices were being respected.

We saw the provider had received compliments from relatives about the care provided. For example, one relative had written in to say 'Thank you for all the care and kindness given to [relative's name]. An excellent home with excellent care staff."

People were supported to maintain relationships with their family and friends. Relatives we spoke with said they could visit Woodland Park anytime they wished. People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as furniture, ornaments and photographs.

We looked at how information was shared with people who lived at the home and their relatives and found that resident and family meetings took place. This was evidenced through minutes of meetings being recorded. We could see that a variety of topics were discussed during these meetings and that people were able to share their views and experiences. However, attendance at such meetings was variable with some well attended and others no so. There was also information leaflets and guides available for people in the hallways.

Good

Is the service responsive?

Our findings

At the last inspection in August 2016 we found improvement was needed in relation to supporting people to maintain their social activities and interests. During this inspection we saw there had been improvement with the employment of an activities co-ordinator, however, some people and their relatives felt further improvement could be made.

People still had mixed views regarding activities that were made available to them. Some people and their relatives told us they were offered activities. One person said, "There is always something going on." Other people and relatives were not so positive about the activities. One relative told us that activities seemed very few and far between, "They have bingo on two afternoons a week, but this had only just been put in place. I suspect it's because they knew you were coming." Another said "They'd had a guitarist in and a keyboard player on another occasion. But there was very little to report in terms of events or entertainment." One person told us they often felt they had no-one to talk to when sat in the lounge but they preferred to sit there than alone in their room all day. Another relative said, "It was nice to have someone come and talk to us because [relative's name] was just saying no-one ever comes in to see him." Most people told us staff did their best but no-one really had enough time to spend with them.

Staff we spoke with told us there wasn't always time to support people with activities. One staff member told us "I think that people would benefit from staff having more time to spend with them." We observed staff interaction with people was mainly task focused whilst they were giving care. We did not observe staff, other than the activities co-ordinator, sitting with people or engaging them in activity.

Since the last inspection the home had employed an activities co-ordinator for sixteen hours a week. We spoke with the activities co-ordinator about their role and their plans to increase social activity within the home. They were extremely enthusiastic and told us, "I make sure there is something going on every day, even when I'm not around." They told us that each person had an individual social activity programme tailored to their interests and hobbies. For example, one person loved fishing. The activities co-ordinator bought them fishing books for them to enjoy and help them to talk about their interests with people and staff. Another person used to enjoy painting but because of their health needs, could no longer paint as they did. The activities co-ordinator made sure they always encouraged them to take part in the arts and craft sessions. We saw them enjoying arts and crafts during the inspection. The activity co-ordinator told us they tried to visit people in their rooms and offer one to one sessions but they had limited time. One to one sessions included, hand and nail manicures, quizzes and word searches and spending time talking.

There was a programme of activities which included sing-a-longs, bingo, arts and crafts, individual activities, reading and movie afternoons. However, we saw that activities were not very well advertised.

The home held a policy on equality and diversity, and training on equality and diversity was planned for later this year. This would ensure that staff were aware of how to protect people from any type of discrimination. Staff were able to tell us how they helped people living at the home to ensure they were not disadvantaged in any way due to their beliefs, abilities, wishes or choices. For example, if people were poorly

sighted staff would read things out to them or support them to recognise where they were in the home. Aids were also available to help people to communicate and make choices, such as, pictorial books. People also had access to audiobooks and sensory games.

Care records showed that people's needs had been assessed prior to them moving to the home and care plans had been developed so that they received appropriate care and support. People's care plans contained information about their health and social care needs. The care plans covered areas such as personal care, eating and drinking, mobility, emotional well-being, elimination and communication needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up or what food they liked to eat. One person's care plan told staff the person enjoyed listening to choral music. Staff told us they would put the music on for them as this helped calm them. We saw the person enjoying their music during the inspection. This told us people received care that was individualised, person centred and based on how they wanted to be treated and looked after.

Care records included information about people's history, previous lifestyle, preferred routines and social interests. People were actively involved in their care assessment and routine care reviews. One person told us that they'd seen their care plan twice and when they had asked them to take one or two things out they'd done so and retyped it so they could sign it. A notice on the notice board informed people and relatives that staff were in the process of updating care plans. The deputy manager told us they were spending time with people writing their life stories. This provided staff with an insight into people's past lives, their hobbies and interests and their family life. Staff told us they used this background information to inform their conversations with people while they were providing care.

People's needs were regularly reviewed through team meetings and daily staff handovers. Arrangements were made for health and social care staff to review people frequently or as their needs changed. Prompt referrals were made to support people's need for additional assessment such as referrals to external agencies such as dieticians and speech and language therapists as required.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. A relative told us about the care their relative and family received from staff at Woodland Park, "They were absolutely amazing. They couldn't do enough for us, I am shocked but in a good way. When dad was near the end of his life they made him feel comfortable and cared for. They would hold the phone to his ear so that he could hear my voice. We are so pleased he was here at the end of his life. They made us feel special."

The deputy manager was very passionate about ensuring that staff help people pass on gracefully and peacefully. They told us, "The end of a person's life is as important as their beginning and any other time in their life and should be treated so." They went on to tell us they made sure staff received end of life training and they had recently completed 'Opening the spiritual gate' training course. Opening the spiritual gate training helps staff to explore the spiritual needs of the individual in order to meet the holistic needs of those at end of life.

Records showed that people had been consulted about their end of life care planning and funeral arrangements, however others had declined to discuss their plans. Where people had chosen to have this conversation their end of life wishes had been recorded.

We looked at the system for managing complaints in the home. A complaints procedure was in place which provided information about the process for responding to and investigating complaints. It gave contact details of people within the home who would deal with people's complaints and how long staff within the

home would take to respond to complaints. It also gave contact details for other organisations and an independent external investigator that could be contacted for advice if people were not happy with how a complaint had been dealt with. Records we saw showed that there was a system for recording complaints and any action taken. However, there was no system for auditing complaints to look for trends and similar themes. One relative said they were happy with how staff had dealt with their complaint. They told us they had complained about food being delivered on cold plates which resulted in lukewarm food. The next time they were there they were delighted to see the food had been served on a hot plate, "The plate was so hot I nearly dropped it."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in August 2016, we identified the provider was not meeting the regulations in relation to governance. At that time, we found that systems and process were not operating effectively to assess, monitor and improve the quality and safety of the service. Records of people's care were not always accurate, complete and contemporaneous.

We identified a number of concerns on this inspection that had not been identified in the service's own quality assurance systems or had not been resolved following the previous inspection of August 2016.

Systems were in place to monitor and assess the quality of the service provided. We found these systems were not always effective to ensure good governance and oversight of the service provided for people living at the home. Issues relating to risk and quality had not always been identified by the governance systems in place. For example, one person needed staff to help them move in bed to prevent pressure damage. Their daily records and charts showed they had not always received this care and quality assurance systems in place had not identified this. Other people's records showed care had been given as documented in the care plans.

The auditing systems did not identify that some care plans and risk assessments were not in place and others did not always give sufficient guidance for staff to provide consistent and appropriate care.

Medicine audits were being undertaken; however these audits had not identified the inaccurate stock record for one medicine and temperatures that were not being monitored in all medicine storage areas.

Management checks and oversight of the service had failed to identify concerns we found with the safety of people due to the security of the home. The registered manager was not aware that one outside exit door did not and could not, be locked which meant anyone could gain access to the home day and night.

This was a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014

The home is owned by Woodland Healthcare Limited who own several homes within the local area. The registered manager was also registered as manager of another home nearby and they split their time between the two services. The registered manager was a registered nurse, they told us they kept their knowledge of care management and legislation up to date by attending training courses, using the Care Quality Commission's website and attending manager's meetings. The registered manager was supported at Woodland Park by a newly appointed deputy manager.

Woodland Park's Statement of Purpose informs people that Woodland Park is committed to provide a high level service and environment for people that live there. The Provider Information Return (PIR) stated that the manager is accessible and approachable, committed to provide support to all levels and develop team responsibilities. There was a positive and welcoming atmosphere at the home and we found the

management team to be very open, transparent and responsive to any concern we raised. They told us that although disappointed by the concerns we found, they were committed to act on the concerns to ensure the home provided the very best care.

People living at the home told us they knew the registered manager but they were often busy. During the inspection we saw positive interactions between the registered manager, people and their relatives. We spoke to people and relatives about the management at Woodland Park. Mainly the feedback was positive, however, two relatives told us they were not happy with the registered manager's attitude and felt they did not know their relative or speak to them in a respectful way. For example, one relative said, "She refers to my mum as Mrs [room number] she doesn't know her at all."

The registered manager told us they were committed to ensuring people received a safe, effective, caring, responsive and well-led service by ensuring staff received continued development to improve knowledge and best practice. We saw that the management led by example and their door was always open for people, staff and relatives to raise any concerns or ask any questions. A health care professional told us they felt the home were making improvements and the management were very responsive and committed to make the necessary changes.

Staff told us they enjoyed working in the home and felt well supported by the management team. One staff member said, "I think [registered manager's name] is brilliant. Everything is dealt with efficiently. I'm quite happy to work here and progress up the career ladder." Another staff member said, "If I speak to [deputy manager's name] about concerns she deals with it straight away. She's fantastic, a really good manager." Staff told us they were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any emergency or concern. There were policies and procedures in place relating to the running of the home. Staff were made aware of the policies at the time of their induction.

Records showed and staff confirmed that staff meetings were held. Staff meetings are a valuable means of motivating staff, keeping them informed of any developments within the home and giving them an opportunity to discuss good practice. We saw from staff meeting minutes and staff told us they could raise any issues of concern in staff meetings and that their views were always listened to. However, one staff member told us that staff meetings were a "bit negative" and felt that staff did not get enough praise or recognition.

Feedback was sought from people, relatives and health and social care professionals as part of the quality assurance process. There were a variety of ways in which they could give feedback. These included annual surveys, residents' and relatives' meetings, care reviews and through the complaints process. Comments from the latest survey included, "An excellent home with excellent care staff" , "Really friendly staff, this place doesn't smell like and old people's home" and "The home have the residents interests as their priority and are well cared for."

Providers of health and social care services are required to notify CQC of significant events that happen in their services such as serious injuries to people and allegations of abuse. The registered manager of the home had made prompt notifications to us of important events, as required. This meant we could check appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises were secure at all times. Some outside doors were left open and one door did not have a lock. This meant that people's personal safety was at risk from uninvited visitors.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems had not been operated effectively to assess, monitor and improve the safety of the services provided, or mitigate the risks.