H W Group Limited

Woodlands House

Inspection report

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Date of inspection visit: 17 & 19 March 2015
Date of publication: 11/05/2015

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?	Requires improvement

Overall summary

This inspection took place on 17 and 19 March 2015 and was unannounced.

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 only require support with some daily living tasks such as personal care or support with their medicines management and the preparation of meals. In addition there is a newer ground floor extension which provides a nine bedded dementia care unit 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. There were 32 people living in the home when we inspected.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

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. A new manager was appointed in August 2014. They have made an application to be appointed the registered manager.

Some areas required improvement. Staff had not always maintained an accurate record of the medicines they administered and we found a number of incidents where people had run out of their prescribed medicines. Some risk assessments needed to be updated to include more detailed and specific guidance to support staff to manage risks in a safe and effective manner.

People told us they felt safe and there were systems and processes in place to protect them from harm. Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team.

Safe recruitment practices were followed and appropriate checks had been undertaken which made sure only suitable staff were employed to care for people in the home. There were sufficient numbers of experienced staff to meet people's needs.

Staff received a comprehensive induction which involved learning about the needs of people using the service and key policies and procedures. Staff were supported to provide appropriate care to people because they were trained, supervised and appraised.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

People told us they were happy with the care provided and said they had good relationships with staff. Comments included, "We really like the staff" and "The staff are brilliant, a lovely bunch, flexible and helpful".

People told us they received personalised care and were encouraged make choices about how they spent their time. People were supported to take part in a range of activities in line with their personal preferences. Complaints policies and procedures were in place. People told us were confident they could raise concerns or complaints and that these would be dealt with.

People spoke positively about how well organised and managed the service was. There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements. There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving appropriate support.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe

Improvements were needed to the management of people's medicines. Staff had not always maintained an accurate record of the medicines administered and more robust arrangements were needed to ensure that people did not run out of their prescribed medicines. Some people's risk assessments needed to be updated more regularly to ensure that all appropriate measures were being taken to manage their identified risks.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Staff were clear about what they must do if they suspected abuse was taking place.

Staffing levels were adequate and enabled the delivery of care and support in line with peoples assessed needs.

Is the service effective?

Good

The service was effective

Staff received a comprehensive induction and undertook relevant training which helped them to deliver effective care.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

People received the support they needed to help them manage their healthcare needs.

Is the service caring?

Good

The service was caring.

People were happy with the care provided and said they had good relationships with staff.

People received support from staff who demonstrated their concern for, and interest in, them. Staff spoke about people in a caring and respectful manner and interacted in a meaningful way with people.

People were treated with dignity and respect and were encouraged to live as independently as possible.

Is the service responsive?

Good

The service was responsive

People told us they received personalised care and were encouraged make choices about how they spent their time.

Summary of findings

People were supported to take part in a range of activities in line with their personal preferences.

Complaints policies and procedures were in place. People told us were confident they could raise concerns or complaints and that these would be dealt with.

Is the service well-led?

Requires improvement

The service was not well led. This was because there was no registered manager in place, although an application is being submitted.

People spoke positively about the manager and for the way in which the home was run.

There was an open and transparent culture within the service and the engagement and involvement of people and staff was encouraged and their feedback was used to drive improvements.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

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 17 and 19 March 2015. The inspection was unannounced.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

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 registered managers to tell us about important issues and events which have happened within the service. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with 13 people who used the service and six relatives. We also spoke with the manager and 10 other staff members. We reviewed the care records of five people in detail and the training and recruitment records for four staff. We also reviewed the Medicines Administration Record (MAR) for 14 people. Other records relating the management of the service such as audits and policies and procedures were also viewed.

Following the inspection we contacted three community health and social care professionals to obtain their views on the home and the quality of care people received.

The last inspection of this service was in May 2014. This inspection only looked at how medicines were managed within the home. We found concerns in relation to the storage of medicines and how 'variable dose' or as 'as required medicines' were managed. We visited the service in July 2014 and found that the required improvements had been made.

Requires improvement

Is the service safe?

Our findings

Each person told us they felt safe living at Woodlands House. One person said they felt "Very safe". A visitor told us, their relative was "Much safer here, it's warm, dry, safe, they are looked after a hundred times better than being at home alone". People told us there were sufficient staff to meet their needs and that they were assisted to manage their medicines safely.

Improvements were needed to the management of people's medicines. We reviewed people's medication administration records (MARs). We found four examples where people had run out of their medicines, sometimes for a period of several days. We spoke with the manager about this. They explained the medicines had been ordered in a timely manner but had not been delivered by the pharmacy. We saw they had made arrangements to meet with the local surgery and their supplying pharmacy to try and address these issues. We saw one person's MAR showed staff were frequently recording that the person was asleep and so they were not able to administer their eye drops. This person had not received their eye drops for almost a month. We were able to see that the service had also identified that this was an area of concern through the completion of their monthly audits and they explained that action was being taken to remind staff about the importance of administering people's medicines. However it was of concern to us that some people were not always receiving their medicines and we found that more robust arrangements were needed to ensure that people did not run out of their prescribed medicines.

Staff had not always maintained an accurate record of the medicines administered. Two people's medicine administration records (MARs) had not been signed on one occasion in the last month to show whether their medicines had been given. Topical cream administration records (TMARs) did not always contain clear guidance on where and how often the creams should be applied. We looked at six people's TMAR and found a number of gaps in each record.

Covert administration of medicines had been authorised for one person by their GP. However the service had not undertaken a mental capacity assessment in relation to this aspect of the persons care and treatment. The person did, however, have a medicines care plan which recorded that the home had consulted with the healthcare professionals, pharmacy and the person's family to agree that administering the medicines covertly was in the person's best interests. This also recorded how the medicines were to be administered covertly.

Staff who administered medication had completed training and the manager carried out competency assessments every six months to ensure they remained safe to administer people's medicines. We observed a medicines round and saw medicine was administered safely to people. People were provided with information about what each of their tablets was for and where people had medicine such as pain relief, which they only took when needed, the care worker asked the person if they needed any before dispensing this. People had detailed protocols in place for the use of other PRN or 'as required' medicines and their MAR recorded whether they had any allergies.

Medicines were kept safely, in locked trolleys or in treatment rooms. The home was currently administering a number of Controlled Drugs (CD). These are prescription medicines controlled under the Misuse of Drugs Act 1971, and which require special storage, recording and administration procedures. We undertook a balance check of the Controlled Drugs held in the CD cupboard against the CD register and these agreed. Arrangements were in place to ensure medicines were being stored within the recommended temperature ranges.

Staffing levels were adequate to meet people's needs Staff employed to work at the home included a 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 36 hours of activities each week. The manager was confident they had a good understanding of the number of staff required to deliver a safe service. The target staffing levels for morning shifts were six care workers plus a head of care. Two of these staff were based in The Cottage and the remainder in the main house. At 2pm the staffing levels reduced to five care workers including a head of care. At night there were three waking staff members on duty. Two of these were based within the main house and one within The Cottage. The manager explained that the home were currently recruiting additional night staff and planned to shortly also have two care workers based in The Cottage. The home had a small team of bank staff and the manager explained they were able to cover gaps in the rota with

Is the service safe?

their existing staff rather than with agency staff. This helped to ensure that people received care from consistent staff who were familiar with their needs. During the day the care staff were supported by housekeeping and kitchen staff. A cook was on duty until 2pm and from 4.30pm – 8.30pm a kitchen assistant was employed to assist with the preparation and serving of supper. This helped to ensure that care staff could focus on supporting people.

Staff responded quickly and people's needs were met in a timely manner. People raised no concerns with us about delays in call bells being answered. One person said, "They come very quickly and if I press the emergency button, they are straight there". People told us they were able to choose when to go to bed and when to get up and that the staffing levels supported this.

Each staff member we spoke with told us that the staffing levels were adequate to ensure that people's essential needs were met. Comments included, "Everyone gets their care" and "Nothing gets missed". Staff confirmed that the manager and senior team spent time on the floor to cover busy periods or breaks. However most of the staff we spoke with told us that one additional staff member on each shift would enable them to spend more time with people. One staff member said, "We don't have time to sit and chat" and "one extra person would mean that you could have real quality time with people".

People's records contained appropriate risk assessments which covered a range of areas. We did note that some risk assessments were not being regularly reviewed. For example, one person's falls risk assessment was dated May 2014, but we were aware that they had experienced a recent fall. Their falls risk assessment had not been updated in light of this fall to ensure that staff were putting in place all of the appropriate preventative measures. A second person's falls risk assessment was dated December 2014. This person was experiencing regular falls but their assessment had not been updated. We were, however, able to see that in this case appropriate medical advice had been sought and a referral had been made to the movement disorder clinic. Whilst staff were generally well informed about each person's risks and the strategies in place to support them, we did see one example, where a person was not sat on a pressure relieving cushion, despite this being part of their risk management plan to prevent pressure ulcers. The manager told us that a second person was meant to have their bed on its lowest setting to help manage the risk of potential injury should they fall from bed. When we visited this person, their bed was on a higher setting. We fed this back to the manager who sent out an immediate memo to all staff reminding them of the importance of following guidance in this person's risk assessment.

Other risk assessments had been undertaken to identify whether people were at risk of malnutrition and people's weight was monitored. Where people were at risk of developing pressure ulcers, their care plans contained information about how this risk was to be managed and a completed pressure ulcer risk assessment. Moving and handling risk assessments were also in place as were assessments relating to the use of bed rails. We saw that the service had taken prompt action to seek specialist advice when one person declined to follow their prescribed diet, increasing their risk of choking. Another person had a detailed risk assessment and plan concerning their risk of absconding from the home. Staff were able to share with us examples of positive risk taking and there was evidence that staff did not restrict peoples interests, instead they were encouraged to take walks in the garden and to retain their independence. People had personal emergency evacuation plans which detailed the assistance they would require for safe evacuation of their home.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation had appropriate policies and procedures and information was available on how staff should report abuse. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Each staff member we spoke with was confident the management team would take prompt action to address any concerns about a person's safety or any allegation of abuse. The manager used supervision to discuss and reflect upon safeguarding issues. This helped staff to develop their awareness about factors that could affect the safety of people living within the home. Staff were informed about the organisations whistleblowing policy and they were clear they could raise concerns with the manager but were also aware of other organisations with whom they could share concerns about poor practice or abuse.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These

Requires improvement

Is the service safe?

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.

Good

Is the service effective?

Our findings

People were positive about the staff and the care they received. One person said, "I would have no hesitation in recommending [the home]" and a second person said, "I can't think of anything they could do better". A relative said, "I would recommend without reservation. People felt staff had the necessary skills and knowledge to effectively meet their needs. One person said, "The staff seemed very well trained, they look after me very well, if I am ill they call the doctor quickly". Overall people were positive about the food. Comments included, "I can have something at any time" and "Very good choice of food". A visitor told us how their relative could often not be motivated to eat. They told us that staff had, "Made every effort to encourage them to eat".

Staff had received training in the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) is a law that protects and supports people who do not have the ability to make decisions for themselves. Staff were able to demonstrate an understanding of the key principles of the Act. They were clear that when people had the mental capacity to make their own decisions, this would be respected. We observed staff asking people before they assisted them with a task such as putting on an apron, helping them with their meal or taking away their finished drinks. Where people were unable to give consent to everyday tasks, such as getting washed and dressed, staff were able to talk about how they made decisions in their best interests taking into account their known wishes. Some aspects of people's care and support had formal mental capacity assessments, for example, a number of people had capacity assessments and best interest's decisions in relation to their safety if they were to leave the home unsupervised. Another person had a capacity assessment around the decision to remain living at the home in light of their increased level of need. We saw evidence that staff were involved in best interests meetings alongside other professionals around other aspects of peoples care and treatment. We did note that where people's ability to consent to their care plan was in doubt, an assessment of their capacity was not routinely undertaken as part of the care planning process. This helps to ensure that the actions covered in the care plan are agreed to be in the person's best interest's and helps to demonstrate that staff are acting in accordance with the principles of the MCA 2005.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people using services by ensuring that if there are restrictions to their freedom or liberty, these have been agreed by the local authority as being required to protect the person from harm. The manager understood when an application should be made and was aware of a recent supreme court judgement that had widened and clarified the definition of a deprivation of liberty. There was one person living at the home who had a DoLS in place and a number of other applications were waiting assessment by the local authority.

New staff received a comprehensive induction which involved learning about the values of the service, the needs of people using the service and key policies and procedures. The manager told us that new staff shadowed more experienced staff for a minimum of 60 hours before they worked independently. Records showed the induction of new staff was in line with the Skills for Care Common Inductions Standards (CIS). These are the standards people working in adult social care should aim to achieve within their first 12 weeks. Staff confirmed they had completed an induction and had found this helpful. One staff member told us their induction enabled them to feel that they knew each resident really well and prepared for their role.

Staff completed a range of essential training. Most of the training programme was delivered by e- learning and included a range of essential training such as first aid, food and nutrition, infection control, and safeguarding people. Moving and handling training was completed via a face to face course. Staff were positive about the training available and told us it helped them to perform their role effectively. Staff completed additional or specialist training if this was needed in order to meet people's needs. One staff member told us, "I wanted to learn more about dementia and they put me on a dementia champion course". Another staff member told us how they were being supported to undertake a course on caring for people with brain injuries. Staff were also supported to undertake additional qualifications in health and social care. This helped to ensure that staff continued to develop their skills and knowledge and that these were in line with current best practice.

Staff told us they felt supported and that they received regular supervision and an annual appraisal. The training

Good

Is the service effective?

and supervision records we viewed confirmed this. A staff member said, "Supervision is useful, it helps you to be a good carer". Another staff member told us how they got constructive feedback in supervision and that this was helping them to develop their skills as a senior care worker.

People told us that the food was tasty and provided in sufficient quantities. A range of choices were available at each meal and a selection of hot and colds drinks were available throughout the day including fortified milkshakes. People had jugs of juice or water in their rooms. Fresh fruit was available in the lounge and offered as an option for dessert. We observed one person ask for toast and tea mid-morning. This was promptly served. One person told us, "You can say you don't like that and you can have something different". People told us they could choose whether to eat in the dining room or in their room. A visitor told us that their relative tended to stay in their room for their meals, but that staff tried to encourage them to come to the dining room as they ate more when they dined with others. This person had been assessed as nutritionally at risk and their relative said that during the afternoon the person was offered a strawberry milkshake and biscuits to encourage extra nutrition. Another resident told us how they went to a local church each Sunday which meant that they were late for lunch. They told us that staff always kept a meal for them and served this upon their return to the home.

We observed lunch-time in both the dining room and in The Cottage. People using the dining room were sat at tables with linen clothes, cutlery, glassware, napkins and condiments. People were offered a selection of drinks including Guinness in celebration of Saint Patrick's day. 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 and manager who was walking round speaking with people. The dining experience in the cottage was quieter with most people taking their meals in the lounge, but staff supported people in an attentive manner.

People's care plans included information about their dietary needs and risks in relation to nutrition and hydration and staff were aware of these. One person had a detailed eating and drinking plan which contained information about seating position, type of diet, clear instructions for how they needed to take their fluids and how they were to be supported to take their meals. Where people were at risk of dehydration or poor nutrition, staff used food and fluid charts to record and monitor their intake. We did note that some of these charts could be more detailed in the information recorded to ensure they were a fully effective tool in monitoring the person's food and fluid intake. We saw that the manager had taken action to research and purchase some moulds which can be used with pureed foods to enhance the presentation of these for people requiring this type of diet.

Where necessary a range of healthcare professionals had been involved in planning and monitoring peoples support to ensure this was delivered effectively. For example, one person had been referred to a speech and language therapist and a second person to a movement disorder clinic. We saw that people were promptly referred to their doctor if they were unwell and effective links were also being developed with the local community mental health team. The service had made arrangements for each person to have a hospital transfer form. This form was reviewed monthly and 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.

Good

Is the service caring?

Our findings

People told us they were happy with the care provided and said they had good relationships with staff. People's comments included, "We really like the staff", "They look after us", "Brilliant" and "Lovely bunch, flexible and helpful". A visitor told us, "The staff are very, very kind and caring, they know about [their relative] and are so patient". Staff spoke about people in a caring and respectful manner. One said, "I treat people as if they are my own family". A second staff member said, "[Staff] here are lovely, they are all kind and caring, it's not just a job for them, it's like it's their life".

Staff spoke passionately about their work and demonstrated a commitment to ensuring that people received good quality care and that their individual needs were met in a ways which made the person feel like they mattered and were valued. One staff member said told us how they had promised to say goodbye to a person before leaving for the day, but forgot to do this. They told us how they had returned to the home in order to say goodbye as they did not want the person to think that they had been forgotten.

People received attention from staff who demonstrated their concern and interest in the person. Staff showed they had a good knowledge and understanding of the people they were supporting and were able to give us examples of people's likes and dislikes which demonstrated that they knew them well. As part of the recruitment process, the manager told us that candidates were asked questions about what it meant to be caring and kind. They told us that they regularly undertook direct observations of staff to ensure that were practising in line with the provider's key values of care, comfort and companionship and promoting a happy atmosphere within the home.

People who used the service, and those who were important to them, were involved in planning their care. People told us they could make choices about how their care and support was delivered and were able to comment on the quality of this as part of their reviews and in resident meetings. We saw that members of the residents committee were involved in interviewing new staff. This helped to ensure that people had a say in who provided their care and support. All of the visitors we spoke with were satisfied that they were involved in relevant decisions and were able to inform people's care plans by sharing what they knew about people's preferences and how they liked to live their lives. Photographs of each staff member, along with their name and role were displayed within the home, which a visitor told us helped them to recognise and become familiar with the staff caring for their relative. Comments from a recent satisfaction survey with relatives confirmed that they felt involved and informed about people's care and support. One comment said that the care was "Excellent, especially keeping me in touch whilst I have been unwell".

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 dignity and respect, kindness and to have their privacy and confidentiality respected. Everyone we spoke with told us 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 that staff knocked on people's doors before entering and addressed them by their chosen names.

People were encouraged to live as independently as possible. Staff told us how they enabled and encouraged people to complete tasks for themselves, even if this took a long time. We saw that people's care plans were written in a manner that encouraged staff to promote people's independence. Where appropriate people had access to adapted cutlery and crockery which enabled them to eat without assistance. We observed that staff encouraged people to continue to take part in activities that were meaningful or important to them, for example, taking a walk in the grounds each day. All of the visitors we spoke with said that they were free to visit their relatives or friends at any time and were always made welcome by staff.

Good

Is the service responsive?

Our findings

People were supported to follow their own interests and to make choices about how they spent their time. We observed that people were able to choose to play the home's piano, or to take walks in the grounds. People were supported to access large print books from the local library to enable them to continue enjoying reading. People told us they were able to make choices about when they got up or went to bed and how or where they spent their time. One person told us they preferred to spend their time quietly reading in the homes library whilst others preferred to sit in the larger main lounge or in the entrance hall. We observed that people appeared relaxed and content. We saw people coming and going from various activities such as flower arranging, jelly making and arts and crafts. We also saw people relaxing around the home, either in their rooms or the lounge or library. Staff chatted with people as they went about their work and these interactions helped create a positive, warm and lively atmosphere within the home.

People's care and support plans were personalised and their preferences and choices were detailed throughout their care records. Where people were unable to share their preferences or information about their life history with staff, this was completed by a family member. This supported staff to know and understand what was important to each person and to deliver responsive care. A member of the senior team had a lead role for ensuring the delivery of personalised care. Staff told us how they delivered personalised care by ensuring that they asked people about their choices and sought their consent before providing care. One staff member said, "I am always asking people what they want, or can I do, I talk with them, there is no rush".

Care plans contained relevant information about people's physical health and their care and support needs which allowed staff to provide care which was responsive to their needs. We saw that people had care plans in relation to their medicines management, mobility, the support they needed to wash and dress, manage their continence and to maintain their skin integrity. People had eating and drinking plans which described, for example, their risk of weight loss and the actions staff should take to promote and encourage calorific intake. One person who experienced breathing difficulties had a care plan relating to this need. We saw that a pharmacy audit had identified that one person's drugs would be more effective if administered on an empty stomach. We saw that action had been taken promptly to put in a detailed care plan around how and when staff should administer this medicine. When needed, short term care plans were put in place, which described the additional care people required to address a specific or acute health need. For example, one person had a short term plan in place with addressed their need for additional monitoring of their skin integrity whilst they were spending more time in bed due to being unwell.

Some people had advanced care plans which described their choices in relation to end of life care. The manager explained that the home were yet to explore end of life care wishes with all people using the service, but that they were committed to developing this area of their care planning to ensure that they were able to support people nearing the end of life in a personalised manner. Staff told us they could refer to people's care plans in order to understand their needs and it was evident that the care plans had been read by staff. This helped to ensure staff understood the needs of the people they supported.

Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. Staff told us that the daily handovers were effective at ensuring they were aware of any changes in people's needs. One staff member said, "Handover works really well, you get to know everything that has happened, what checks are needed and whether any incidents have taken place". Regular reviews took place, during which people, their friends and family were asked to give their views and feedback about the care and support they received, this helped to ensure people's daily support remained relevant and purposeful.

The service employed two activity coordinators who helped to provide a range of activities six days of the week. Activities available included, trips out, music for health sessions, quizzes, flower arranging, arts and crafts, manicures and cooking sessions. All of the people and relatives we spoke with were positive about the quality and quantity of the activities. Two staff told us that they felt it would be beneficial for the activities staff to spend more

Good

Is the service responsive?

time in The Cottage providing an activities programme which was specifically tailored to the needs of people living with dementia, including the provision of more one to one interaction.

Complaints policies and procedures were in place and people and their relatives told us they were confident that they could raise concerns or complaints and that these would be dealt with. The service had received one complaint in 2014. We found that this had been responded to in a timely manner and the records showed this has been investigated and appropriate actions taken to address the concerns.

Requires improvement

Is the service well-led?

Our findings

Woodlands House had not had a registered manager since June 2014. The current manager was appointed in August 2014 and is in the process of submitting an application to become the registered manager. Until the home has a registered manager application accepted by the Care Quality Commission (CQC) we are only able to judge that the leadership of the service requires improvement, however, people spoke positively about how well organised and managed the service was. One person told us the manager was, ""Absolutely wonderful". Another said, they were, "Excellent, really, really top hole". People told us that they regularly saw the manager and that she visited them in their room and was approachable. Staff were also positive about the leadership of the service, their comments included, "I feel well supported", "They [the manager] are always out on the floor, they always want to keep up to date with everything", "The leadership is very visible, [the manager] gets involved in providing care" and "I wouldn't be in this position without [the manager], they have made such a difference, moral is good, there is no-one better to work with".

There was an open and transparent culture within the service and the engagement and involvement of people and their relatives was encouraged and their feedback was used to drive improvements. People took part in a residents committee meeting each month. A member of the committee told us that the purpose of these meetings was to resolve any issues of concern to residents and to highlight these to the management team. They told us that the issues raised were rectified. For example, we saw that people had asked for larger plates and these had been provided. People had expressed concerns that the steps outside the front entrance could be difficult to see. The manager told us that special paint had been ordered to enhance the visibility of the steps but that this had not been fully effective and so other measures were also being considered. Relative meetings were also held. We saw that at a recent meeting relatives had made some suggestions about additional activities that could take place. We saw that in response beauty pamper and knitting sessions had taken place and a mobile clothing sale had been arranged for April. This demonstrated that people's views were listened to and that the manager acted upon feedback from people and their relatives.

Staff meetings were held periodically. There was evidence that issues were discussed with staff such as developments within the service and how staff might enhance the care people received. We saw that staff were reminded of the importance of reporting any concerns about the safety or welfare of any of the people using the service. Staff told us, they felt able to make suggestions and come up with ideas which were taken seriously. One staff member said, "They don't hide in the office, their door is always open, you can go in anytime, and get involved".

Staff had access to training, supervisions and professional development. They were encouraged to gain further qualifications and extend their knowledge. Staff demonstrated a clear understanding of their role and responsibilities. The organisation had its own awards scheme to recognise staff for the quality of their work. This helped to ensure that people were supported by motivated, suitably trained and skilled staff.

The service had systems in place to report, investigate and learn from incidents and accidents. There was evidence that detailed investigations were undertaken following incidents and that appropriate actions were taken in response. Following accidents, we saw that people were, for example, referred for a medical review or to falls clinics. Each month the 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.

There were a range of 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. Audits were completed on a monthly basis by

the manager or senior staff. These included areas such as care plans, infection control and medication as well as checks of equipment, the premises and fire safety. Where gaps, omissions or areas for improvement were noted, we were able to see that clear actions had been taken to address these. Actions included, using reflective supervision or retraining staff. The regional manager also visited the home on a monthly basis and undertook audits of all areas. These were recorded and their findings shared with the manager to act upon. This helped to ensure the service was constantly developing and improving. We recommend, that the manager consider developing a service wide improvement plan to clearly detail all of the

Requires improvement

Is the service well-led?

areas where audits, feedback or the outcome of satisfaction surveys have identified that improvements could be made, the steps needed to deliver these and a timescale for completing these.

The manager had a clear vision for the service and told us about improvements they and the provider intended to make in the future. The manager explained that they understood moving into residential care was a big decision for people, but they wanted people to be able to feel that their lifestyle and choices did not have to change. They explained that they did not want people to feel like they had to fit in with the homes routines or mealtimes. In line with the provider's values, they expressed a commitment to ensure the focus and perspective of the service was the person and meeting their needs in a personalised manner.

The manager had a good understanding of the challenges facing the service and the areas where improvements or developments were needed. They explained that recruiting and retaining staff had been a challenge but that they had not needed to use any agency staff for two weeks. They were positive that that this trend would continue with the impact being that people received consistent and high quality care from a hard working team of whom she was really proud. They also told us that they were committed to their own continuing professional development and had enrolled on the Level 5 Diploma in Leadership for Health and Social Care to enhance their skills and knowledge.