WCS Care Group Limited

Woodside

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Woodside on 22 February 2016. The inspection visit was unannounced.

Woodside provides accommodation for people in a residential setting and is registered to provide care for up to 40 people. There were 35 people living at the home when we inspected the service. People were cared for over three floors of the home.

A requirement of the provider's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection. We refer to the registered manager as the manager in the body of this report.

At our previous inspection on 26 August 2015 we found the provider was not meeting all of the required standards. We identified one breach in the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found care and treatment was not always provided with the consent of the relevant person. We asked the provider to make improvements in this area. The provider had sent to us an action plan by the required date which stated all of the required improvements would be undertaken by the end of November 2015. During this inspection we checked improvements had been made. We found sufficient action had been taken in response to the previous breach of the regulations.

The manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made applications to the local authority where people's freedom was restricted in accordance with DoLS and the MCA.

Staff received training in safeguarding adults and were able to explain the correct procedure to follow if they had concerns. All necessary checks had been completed before new staff started work at the home to make sure, as far as possible, they were safe to work with the people who lived there.

Each person had a care and support plan with detailed information and guidance personal to them. Care plans included information on maintaining the person's health, their daily routines and preferences. We found people were supported with their health needs and had access to a range of healthcare professionals where a need had been identified. There were systems in place to ensure that medicines were stored and administered safely.

The manager and staff identified risks to people who used the service and took action to manage identified risks and keep people safe. People were encouraged to eat a balanced diet that took account of their

preferences and where necessary, their nutritional needs were monitored.

There were enough staff employed at the service to care for people safely and effectively. New staff completed an induction programme when they started work to ensure they had the skills they needed to support people effectively. Staff received training and had regular meetings with their manager in which their performance and development was discussed.

Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This helped people maintain personal relationships with people that were important to them.

People were supported in a range of activities, both inside and outside the home. Staff were caring and encouraged people to be involved in decisions about their life and their support needs. People were able to make decisions about their environment and choose how their bedroom was decorated which made it personal to them.

People who used the service and their relatives were given the opportunity to share their views about how the service was run. People knew how to make a complaint if they needed to. Complaints received were fully investigated and analysed so that the provider could learn from them. The provider acted on the feedback they received to improve their service.

Quality assurance procedures were in place to identify where the service needed to make improvements. Where issues were identified the provider acted to make the necessary changes to its service. There was a culture within the home to learn from accidents, and incidents and to continuously improve the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living at the home. People were protected from the risk of harm as staff knew what to do if they suspected abuse. Staff identified risks to people who used the service and took appropriate action to manage risks and keep people safe. Staff had been recruited safely and there were enough staff available to meet people's needs. Medicines were stored and administered to people safely.

Is the service effective?

Good

The service was effective.

Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. Where people could not make decisions for themselves, people's rights were protected because important decisions were made in their 'best interests' in consultation with health professionals. People received food and drink that met their preferences and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

Staff were friendly and people were comfortable in their company. Relatives spoke positively about the care and support received by their family member. People's privacy and dignity were respected and people were supported to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

People were encouraged to take part in activities and follow their interests. Care plans provided staff with the information they needed to respond to people's physical and emotional needs. People and their relatives were involved in the development of care plans which were regularly reviewed. People were able to

make complaints about the quality of the service which were analysed to identify areas where the service could be improved.

Is the service well-led?

Good

The service was well led.

The manager and staff were approachable and there was a clear management structure in place to support staff. The manager was accessible to people who used the service, their relatives, and members of staff. There were systems in place so people who lived in the home could share their views about how the home was run. Checks were carried out to identify any areas where the quality of the service could be improved. There was a culture within the home to learn from accidents and incidents and to continuously improve the service provided.

Woodside

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 inspection took place on 22 February 2016. The inspection was unannounced. This inspection was conducted by two inspectors.

At this inspection visit we checked that the provider had made appropriate changes following an incident at the home in June 2015. The incident is subject to a separate investigation and is not referred to in this report.

We reviewed the information we held about the service. We looked at information received from statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home.

We also reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they planned to make. We found the PIR reflected the service provided.

We spoke with nine people who lived at the home and three people's visitors or relatives. We spoke with two care staff. We also spoke with the registered manager, two service managers, the deputy manager, two care co-ordinators and the deputy director of operations.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records about people's care including six care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

There was a relaxed and calm atmosphere in the home and the relationship between people and the staff who cared for them was friendly. People did not hesitate to ask for assistance from staff when they wanted support. This indicated they felt safe around staff members. People told us, or indicated to us with smiles and hand gestures when asked, they felt safe at the home. One person told us, "I feel safe here and I have a key to my room if I need it."

People were supported by staff who understood their needs and knew how to protect people from the risk of abuse. Staff attended safeguarding training regularly which included information on how they could raise issues with the provider and other agencies if they were concerned about the risk of abuse. Staff told us the training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone's safety. One staff member said, "If there was an issue I would report it straight away to the manager. I know they would look into things. If I was still concerned I know how to raise this myself or escalate any issues to other senior managers." We found the provider notified us when they made referrals to the local authority safeguarding team where an investigation was required. They kept us informed with the outcome of the referral and any actions they had taken that ensured people were protected.

The provider's recruitment process ensured risks to people's safety were minimised. The provider had recruitment procedures to ensure staff who worked at the home were of a suitable character to work with people there. Staff told us, and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce the potential risks. This was important as we had identified risk assessment and management required improvement at our inspection in August 2015. Most of the risk assessments we reviewed were detailed, up to date and were reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, one person needed assistance to move around. There were plans which informed staff how the person should be assisted including the number of staff required to support the person safely and the equipment staff should use. Staff confirmed they referred to the information in risk assessments and care records to manage risks to people. We were given consistent, detailed information by staff on the risks facing individuals.

However, we found two care records where the risk assessments regarding people's use of a lap strap was not up to date. Although the care records stated people used a lap strap to prevent them from falling from their chair, information in the risk assessment was not detailed enough to inform staff under what circumstances the strap should be used. We spoke to two members of staff about how people should be supported to use the lap straps. Staff were knowledgeable about those who needed to use the equipment.

We found staff were using the equipment to reduce the risks of people falling from their chairs and people were supported safely. We brought this to the attention of the manager during our inspection visit who immediately updated the records to ensure people received consistent support from staff.

People told us there were enough staff to care for them effectively and safely. We observed there were enough staff during our inspection visit to care for people effectively and safely. Staff were available to respond to people's requests for assistance. For example, one person asked a member of staff for their cardigan as they were cold, the member of staff went to fetch it straight away and helped the person to put it on, very gently, making sure it was pulled down properly at the back to keep them warm. We saw that in addition to the care staff on shift, there was the manager and a duty manager available to cover care duties at the home when needed. Other staff members worked alongside care staff, such as activities co-ordinators, cleaners and kitchen assistants. This meant care staff could concentrate on providing care support to people who lived at the home.

We asked staff whether they felt there were enough staff at the home to meet people's needs safely. We received mixed feedback from staff about the numbers of staff on duty at the home. One member of staff told us, "We could do with more permanent members of staff to cover all the shifts, but the manager is recruiting staff at the moment." They added, "The mornings are the busiest time, sometimes people need to wait for assistance for a few minutes if people want to get up at the same time." Another member of staff told us, "There could be more staff on during the night shift. There are only three members of staff on at night, one on each floor. This means that if people need two members of staff to assist them, staff need to work across the floors to help each other. It would be good to have a fourth member of staff on at night to help out." A third member of staff told us, "I think there are enough staff on now at night. There is one member of staff who starts work at around 6.30am as a fourth person, they help people get up when they want to and assist the other staff on each floor. I think this is working well."

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, their needs and their dependency level. We saw each person had a completed dependency tool in their care records. This assessed how much care and support they required. The provider and manager used this information to determine the numbers of staff that were needed to care for people on each shift. Staffing levels reflected the identified needs of people. We asked the manager about the number of staff vacancies at the home, they told us they were currently recruiting more staff to cover their existing shifts so that the use of agency staff could be reduced. There was one permanent staff vacancy at the home for an activities co-ordinator. The manager told us they were able to use agency staff and staff from the provider's other homes if needed.

People's medicines were managed safely and only administered by staff who were trained and continually assessed as competent to do so. Medicines were stored safely and securely in line with best practice and manufacturers guidelines. Administration records showed people received their medicines as prescribed. We asked people whether they received their prescribed medicines when they needed them. People told us they did.

Medicines were delivered by the pharmacy in named, sealed pots, colour coded for the time of day they should be administered with an accompanying medicines administration record (MAR) and a picture and description of each medicine in the pot. Each person's MAR included their photo, the name of each medicine, the frequency and time of day it should be taken, which minimised the risks of errors. Daily and monthly medication checks were in place to ensure medicines were managed safely and people received their prescribed medicine.

Some people required medicines to be administered on an "as required" basis. There were detailed protocols for the administration of these types of medicines to make sure they were given safely and consistently. For example, in one person's records we saw staff should look for specific facial expressions and body language to indicate if the person was in pain, as the person was unable to tell staff whether they were in pain. Staff should then administer the medicines based on whether the person needed to receive them. We observed staff following these protocols.

Good

Is the service effective?

Our findings

People told us staff had the skills needed to support them effectively and safely. We observed staff used their skills effectively to assist people at the home. For example, some people at the home had limited language skills. Staff used their knowledge and communication skills to understand the wishes of people. They communicated with people using clear language and tailored their communication according to the individual's needs and abilities. Staff bent down to speak to people at eye level and watched people's expressions to understand their wishes.

Staff told us they received an induction when they started work which included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. One member of staff said, "Our initial training is good, it gave me the skills I needed to support people when I first started." The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. This demonstrated the provider was following the latest guidance on the standard of induction care staff should receive.

Staff told us the manager encouraged them to keep their training and skills up to date so they could support people at the home effectively. One staff member told us, "We have all received training in supporting people with a diagnosis of dementia now, this has helped me understand the condition and communicate with people more effectively." The manager maintained a record of staff training and staff performance, so they could identify when staff needed to refresh their skills. The manager told us the provider encouraged staff to keep their training levels up to date, providing staff with regular training in areas they needed to support people at the home. The provider invested in staff's personal development, as they were supported to achieve nationally recognised qualifications. One staff member commented, "The provider is investing in my personal development, I have just been promoted and I am currently taking on some Level 3 study to enhance my skills."

Staff told us they had regular meetings with their manager where they were able to discuss their performance and identify any training required to improve their practice. They also participated in yearly appraisal meetings where they were set objectives for the following 12 months and their development plans were discussed. Staff told us they found the meetings helpful with one staff member explaining, "We have regular meetings with our managers. Even if we don't have a scheduled meeting coming up you can request a meeting at any time to discuss any concerns you have, or your personal development."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the manager was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager explained to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Records showed the manager had undertaken mental capacity assessments, to determine which decisions each person could make for themselves and which decisions should be made in people's best interests. People or their representatives, had signed to say they consented to how they were cared for. Decisions that were made in people's best interests were recorded, for example, where people did not have the capacity to agree to live at the home recorded decisions had been made in consultation with a team of health professionals. In addition, the manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Three people had a DoLS in place at the time of our inspection visit which demonstrated the manager had made the appropriate assessments in accordance with the MCA. The registered manager had applied to the supervisory body, for the authority to deprive 29 people of their liberty, because their care plans included restrictions to their liberty, rights and choices. The registered manager was awaiting the supervisory body's decisions for 26 at the time of our inspection.

Care staff told us they had received training in the MCA and DoLS and explained the principles associated with the Act. We saw care staff followed the code of conduct of the Act by asking people whether they wanted assistance before supporting them. For those people who were unable to communicate verbally, staff maintained eye contact and watched the person's facial expression and body language, to understand whether they consented to support.

People told us they enjoyed the food on offer at the home. One person told us, "The food is lovely." They added, "Today we had beef stew and dumplings and my favourite treat, cheesecake and cream." Another person commented, "The sandwiches are very nice." We observed a lunchtime meal during our inspection visit. There were a number of dining areas available for people to use. The dining rooms were calm and there was a relaxed atmosphere. People told us they could choose where to eat their meal, one person said, "I like to eat in my room." We saw people sitting together were served their meals at the same time. Where people needed assistance to eat their meal, staff assisted people at their own pace and waited for people to finish before offering them more food.

People were offered a choice of meal each day before their meal was prepared. We saw a menu was on display in the dining room which showed pictures of the meal choices on offer. People were also shown their meal choice before they were served their food. This enabled people to make a more informed choice. One staff member told us, "When people see their meal, if they don't like what's on offer, we can always provide an alternative." We saw one person changed their mind about their meal choice during the lunchtime. Staff immediately prepared the person an alternative. A relative told us, "There is plenty of choice to eat. They try to encourage [Name] to eat, but they don't always want it. They like toast and jam and the staff assist them with this."

People were offered food that met their dietary needs. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet or fortified diets (where extra calories are added such as cream or butter). Information on people's dietary needs was kept up to date and included people's likes and dislikes. One member of staff said, "We are always informed of any specialist dietary requirements. There is a list for us to refer to when we serve people their meals." We saw where it had been recommended a person have a specific diet by health professionals, staff kept a record of the amount of food and fluid the person ate and

drank, and recorded their weight, to ensure their nutrition was maintained. One person told us, "I had lost weight when I came out of hospital. They weighed me every day for a while (until this settled down). Now they weigh me weekly."

Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. We saw fruit, biscuits and drinks were available throughout the day in the dining areas of the home. One person confirmed, "We have tea and biscuits." Another person told us they could have a second helping of their meal when they wished saying, "I have lovely hot breakfast sandwiches here. Sometimes I have two." We observed people and their relatives helping themselves to drinks and snacks in the kitchen and the café areas throughout our inspection visit. This assisted people to maintain their nutrition and hydration.

Staff responded to how people were feeling and to their changing health or care needs because they were kept updated about people's needs. There was a handover meeting at the start of each shift attended by care staff and care coordinators where any changes to people's health or behaviour was discussed. Information was written down in a handover log, so that each member of staff could review the information when they started their shift. One member of staff said, "The handover is really useful and detailed. It gives you all the information you need." We reviewed a recent handover record which showed each person's care and support needs were discussed. The handover records were reviewed each month at a monthly household meeting, so that staff could review any changes to people's health to ensure their support requirements and care records were kept up to date. A member of staff told us, "The staff act really quickly if people's health changes. When we notice an issue we make a referral to a health professional to seek support. For example, if someone was coughing or losing weight we would refer them straight away to the speech and language team."

Staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals so that any advice given was recorded for staff to follow. Records confirmed people had been seen by health professionals when a need had been identified, these included their GP, speech and language therapists, dieticians and chiropodists. The manager confirmed the district nursing team and GP visited the home on a regular basis, when a need was identified. One member of staff told us, "When anyone needs to see the district nurse or the doctor we just make a call and ask them to come in. They would come in daily if needed." They added, "People can also be supported to attend visits with health professionals outside the home if they wish."

We found that care records were updated following the advice of health professionals and people were receiving the care they needed. For example, in one person's care record we saw they should be encouraged to use the toilet to maintain their health and independence. We saw staff frequently asked the person whether they needed to go to the toilet, as advised. In another person's records we saw they should be given nutritional supplements following their meal to increase their nutritional intake. We saw staff encouraged the person to eat their meal and then offered them their nutritional supplement.

Good

Is the service caring?

Our findings

We asked people if they enjoyed living at Woodside. They responded with smiles and said they did. A relative told us, "The carers are very good. The staff are lovely." Another relative commented, "The staff are very nice. They are very patient."

We observed the interaction between the staff members and the people for whom they provided care and support. We saw staff treated people in a kind and respectful way and knew the people they cared for well. People sang, smiled and chatted with staff and each other.

People were treated with respect and dignity. Staff referred to people by their preferred name and staff asked people's opinion and explained what they were doing when assisting them. For example, where people were offered support from staff to move safely staff explained how they intended to assist the person and waited for people to respond before proceeding.

People and their relatives were involved in planning their own care and where possible people made decisions about how they were cared for and supported. For example, people had been consulted about how they wanted their care to be delivered according to their religious and cultural backgrounds, for example, whether they attended religious services at the home or had specific food preferences. We saw people were invited to, and could join in, multi-denominational services which were held weekly in a communal area at the home. This helped people to maintain their religious beliefs in accordance with their wishes.

People were able to spend time where they wished, and were encouraged to make choices about their day to day lives. Staff respected the decisions people made. For example, we saw one person spending time in their room with a relative instead of in the communal area of the home. Other people decided when they wanted to get up and have their meal. One person commented on their daily activities saying, "I don't know where the time goes. I always seem to be busy. I like to go to my room and tidy up a bit."

We saw a number of bedrooms at the home which were arranged differently depending on the person's wishes. There were ornaments and photographs of family and friends, personal furniture and their own pictures on the walls. People told us they had been involved in choosing the decoration and furniture in their rooms. One person told us, "It's lovely here. I have my own room and can arrange it how I like."

Each person had an individual front door to their room. Doors had pictures of the individual, or of items or events they remembered, to assist them in locating their room and to make the environment more personal. We saw people's privacy was respected. Some people had keys to their rooms and were able to lock their bedroom door when they wished. Staff knocked on people's bedroom doors before announcing themselves. We saw people's personal details and records were held securely at the home. Records were filed in locked cabinets and locked storage facilities, so that only authorised staff were able to access personal and sensitive information.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home and were supported to maintain links with friends and family. People and their visitors were offered drinks and snacks and used communal areas of the home which helped to make them feel welcome. A relative told us, "You are welcome to visit when it suits you and your relative."

Good

Is the service responsive?

Our findings

Staff had a friendly approach to people and were responsive when they requested support. One person told us how staff helped them meet their individual needs, in a way that was important to them. They said, "They do my laundry. It's lovely. It comes back the next day and the woollens are lovely." A relative confirmed, for one person who especially wanted to always be clean and fresh, staff were responsive to the person's wishes. They said, "They always have a clean nightie and clean sheets."

People and their relatives confirmed staff helped them promptly when they required assistance. One relative said, "When we asked them to move the TV so [Name] could see it, they moved it the next day. [Name] likes watching TV."

Care records were available for each person who lived at the home which contained detailed information and guidance personal to them. Records gave staff information about how people wanted their care and support to be delivered. For example, records contained details about people's life history, individual preferences such as when people wanted to get up and go to bed, how they wanted their room and their food likes and dislikes. This information helped staff to support people as they wished. For example, we saw one person who enjoyed listening to classical music in their room. We noticed on the day of our inspection visit the person was laying comfortably in their room with classical music playing.

People and their relatives told us they were involved in making decisions about their care and how support was delivered. One relative confirmed their family was involved in planning their relative's care saying, "[Name's] granddaughter assisted with the care planning." The Provider Information Return (PIR) confirmed care planning was undertaken with the person and their loved ones where appropriate. As part of the care planning process people's care needs were assessed and information was collected about what the person was able to do themselves. This helped staff tailor support plans around the abilities of each individual. Care reviews were undertaken monthly by staff so that people's care records reflected their current support needs. Reviews also took place each year with the person and their representatives to ensure people continued to be involved in making decisions about their care and support needs.

People were supported to take part in activities which they enjoyed, according to their own personal preferences. One person told us, "Sometimes we have a sing-a-long." Another person commented, "I could go and use the computer screen if I'm in the mood." A relative told us, "[Name] enjoyed going to the hairdresser's last week and had a cut and blow dry." During our inspection visit we saw people take part in a group activity in a communal area of the home, as well as individual one to one activities. The provider had implemented an accredited training programme called 'Our organisation makes people happy' (Oomph) to deliver activity and exercise sessions. We saw people taking part in a group 'Oomph' session, which included catching objects, moving to music and singing to well-known songs. The session prompted laughter and dancing.

People told us they were encouraged to take part in activities if they wished, but where people made a decision not to join in; their decision was respected by staff. One person confirmed this saying, "They have

the 'Oomph' exercise today. I didn't want to go though."

We asked the manager how people were involved in choosing the activities and events on offer at the home. They responded saying, "We ask people what they enjoy. Their preferences are recorded in their care records, which we regularly update. We also assess what activities people are able to join in, so that each person has an activity plan which is personal to them." We saw the care records reflected the information the manager had provided. We also saw people were invited to take part in regular meetings at the home where activities and events were discussed and planned. On the day of our inspection visit we saw a list of planned activities on display at the home so people could plan what events they might enjoy attending. This included trips out and about in the local community and entertainers visiting the home. This showed the activities were organised to suit the people who lived there.

Information displayed in the communal reception informed people about how to make a complaint and provide feedback on the quality of the service. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. However, the people we spoke with during our inspection visit told us they had no complaints. In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The manager met and discussed complaints with complainants and acted to resolve issues to their satisfaction. For example, following a recent complaint the manager had removed an item of furniture from a person's room. In another complaint the manager had investigated why there was a delay in obtaining some medical equipment for a person. This showed the manager acted to improve the quality of their service following people's feedback.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. People and staff told us the manager was accessible and approachable. The manager operated an 'open door policy' and encouraged staff and visitors to approach them in their office without prior appointment. We saw the manager's and the duty manager's name was displayed in the reception area, so visitors knew who to ask for if they had any concerns, whenever they visited. We saw people, visitors and staff approached the manager throughout the day during our inspection visit. The manager was available when people asked for their support. One relative told us, "I know who the manager is. I can also speak to staff if I want to know anything."

There was a clear management structure within Woodside to support staff. Staff members told us the manager was approachable and they felt well supported. One staff member told us, "Yes the manager is really supportive." They added, "We all work as a team here." Another staff member said, "The manager is brilliant, I can ask them anything. The deputy manager is good too." The registered manager was part of a management team which included a daily duty manager and senior care staff or care coordinators. Care staff told us they received regular support and advice from managers and care coordinators to enable them to do their work effectively. Care staff confirmed there was always an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to. One staff member said, "There is always someone on call if you need support or advice." This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

Staff understood the values and vision of the provider, putting people at the heart of what they did at Woodside. The Chief Executive had personally delivered training sessions to managers about their vision, values and philosophy, this training was planned for all staff. The training included all staff signing up to, "Choose your attitude, (by parking the personal), be there, play and make their day." The vision and values included a charter of what people should be able to expect of the organisation. Not all the staff had attended this training yet, but we observed information about the values and vision on display in areas where staff enjoyed their breaks. We observed staff acting according to the vision on the day of our visit, ensuring each person's choices and capabilities were respected and displaying a cheerful and upbeat attitude.

The provider had plans in place to move people from the home to a new site which was under construction. The new site was due to be finished in late 2016. We found the provider had consulted people who lived at the home, their relatives and the staff group about the proposed change. We saw everyone at the home had been consulted about whether they wanted to move, or whether they wanted to return to the existing Woodside site following some planned renovations. Only one person had chosen to return to the existing Woodside site as they preferred its location. Information was available in the reception area of the home to inform any visitors about the proposed move. Care staff told us they felt their views were listened to by the management team as they were able to raise any issues of concern with their manager or to the provider. A member of staff told us, "We can make suggestions. I could talk to the manager and the management team at any time." We found the manager and provider had acted on some feedback from staff regarding the proposed moved. They planned to assist staff with travelling to the new site as part of their relocation

planning.

There was a system of internal audits and checks completed within the home to ensure the safety and quality of service was maintained. The provider directed the manager to conduct regular checks on the quality of the service in a number of areas. For example, the manager conducted checks in medicines management, care records and health and safety. The provider's service manager monitored the quality of the home through regular visits, during which they checked the manager's records, looked around the home and spent time listening to what people and visitors had to say about the service. For people who were not able to express themselves verbally, a service manager spent time sitting and observing, using a recognised care evaluation tool, which allowed them, to assess whether an individual obtained a good outcome from any everyday event or interaction with staff.

The provider offered the manager regular feedback and assistance with their role. The manager said, "I have weekly visits from a service manager. I also have regular quality assurance visits from the provider to check aspects of the service and discuss areas for improvement at the home." The manager delivered monthly reports to the provider so they could be assured care was delivered and monitored consistently across their group of homes. The provider shared monthly statistics which enabled managers to compare their performance and learn from others. For example, the provider monitored how many people were at risk of poor nutrition, the number and causes of accidents, incidents and falls and how complaints were handled. The manager attended regular meetings with other registered managers to discuss the monthly reports, to reflect on their practice and share ideas. They said, "We have regularly managers' meetings to discuss all areas of our job. We all work as a team. I am able to visit other homes in the group to share ideas and learn with others, to reach a positive outcome for the people we support."

The provider's quality assurance system included asking people, relatives, staff and other health professionals about their experience of the service. A yearly quality assurance survey asked people what they thought of the food, their care, the staff, the premises, the management and their daily living experience. The provider took action to improve the quality of the service based on the results of the surveys. For example, in response to a recent survey the provider had introduced a seven day laundry service. In addition, people were encouraged to share their opinions about the service through residents' meetings, relative support groups, comment cards placed in the reception area of the home, and via a hotline number to the provider. The provider told people about the feedback they received, and the action they had taken through a regular newsletter that was posted in the entrance hall of the home.

The registered manager's role included checking staff monitored and reported their findings to make sure appropriate action was taken when necessary and to minimise the risk of a re-occurrence. Records showed, for example, medication errors, accidents and incidents were analysed by the individual affected, the time and location of the incident, the possible causes and the actions taken. Actions taken as a result of analysis included referring individuals to other health professionals, refresher training for staff and sharing information with relatives, the local safeguarding team and CQC.

The provider learnt from their experience and took action to improve. When issues arose at any of the homes in their group, they investigated the issue and applied their learning across all the homes. For example, following a recent issue the provider had reviewed and updated their policy for assessing people's mental capacity and how they recorded this when they made decisions in people's 'best interests'.

The provider's emphasis was on continually striving to improve by implementing innovative systems and practices. A management team had visited an internationally recognised provider of excellence in dementia care to learn about their methods and planned to introduce their methods into the newly built home. The

registered manager told us the building plans included the introduction of a spa, café and larger shop to promote people's sense of independence. In addition the provider was introducing electronic record keeping at the newly built home to ensure care records could be kept up to date by staff when changes occurred to people's health or their support needs.

The registered manager understood the responsibilities of their registration and notified us of the important events as required by the Regulations. They were proactive at keeping us informed of issues or concerns raised by relatives and other health professionals, in accordance with the provider's policy of openness and transparency. They sent us notifications about important events at the service and their provider information return (PIR) explained how they checked they delivered a quality service and the improvements they planned. A copy of our previous inspection report and ratings were displayed in the reception area for all to see.