Four Seasons 2000 Limited

Woodview

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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 28 February 2017 and was unannounced.

Woodview is registered to provide accommodation and nursing and personal care for up to 63 older people, younger adults or people living with a dementia type illness. There were 56 people living at the service on the day of our inspection. The service is divided into two units. "Woodview" provides care to older people or people living with a dementia type illness and "Greenwood" provides care for younger adults with physical disabilities or long term medical conditions.

There was a registered manager in post at the time of our inspection, although they were not present on the day of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act, 2005 and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. This is usually to protect them. The management and staff understood their responsibility and made appropriate referrals for assessment. Four people at the time of our inspection had their freedom restricted under a DoLS authorisation.

People were not always protected from avoidable harm because not all risks had been identified. Staff were aware of the signs of abuse and knew how to escalate their concerns. There were sufficient staff on duty to keep people safe and meet their care needs. People received their medicine safely from staff that were competent to do so. However, some protocols were not in place for the safe administration of "as required" medicines. People were cared for in clean environment.

People received effective care from skilled and knowledgeable staff who received training to meet most people's care needs. Some staff lacked the skills to care for people when they became anxious or distressed. Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and where able people were asked for their consent to care. People were not involved in planning their menus and their feedback on their choice of food was not actioned. People were supported to access their GP, dentist and other appropriate healthcare professional when needed.

People were cared for with kindness and compassion by committed and caring staff. Staff involved people and their families in decisions about their care. People were cared for by staff who respected their privacy and dignity.

People received care that was personal to their individual needs. Staff supported people to engage in

meaningful activities and pastimes of their choice, both in and outside the service.

The registered manager has been absent for some time and staff were concerned about the lack of visible leadership and support. There were systems in place to monitor the quality of the service, but these systems did not always identify areas for improvement.

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.

Staff had access to safeguarding policies and procedures and knew how to keep people safe from the risk of abuse.

People received their medicines from staff who had the competencies to administer them safely.

People did not always have their risk of harm assessed appropriately.

There were enough staff on duty to meet people's needs.

The service was clean and odour free.

Is the service effective?

Good

The service was effective.

People received a balanced diet but were not involved in menu planning and their food likes and dislikes were not always considered.

Staff had received appropriate training, and understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were cared for by staff who had the knowledge and skills to carry out their roles and responsibilities. However, some staff did not always feel confident with certain aspects of their role.

People had their healthcare needs met by appropriate healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff had a good relationship with people and treated them with kindness and compassion.

People were treated with dignity and staff members respected their choices, needs and preferences.

Is the service responsive?

Good

The service was responsive.

People's care was regularly assessed, planned and reviewed to meet their individual care needs.

People were encouraged to maintain their hobbies and interests including accessing the local community.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had completed regular quality checks to help ensure that people received safe and appropriate care. However, these quality checks did not always identify areas of risk.

There was an open and positive culture which focussed on people and staff.

Staff did not always feel supported in their roles.

Woodview

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 on 28 February 2017and was unannounced. The inspection team was made up of one inspector a specialist advisor for people with nursing care needs and two experts by experience.

An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

A specialist professional advisor is a person who has expertise in the relevant areas of care being inspected, for example, nursing care. We use them to help us to understand whether or not people are receiving appropriate care to meet their needs.

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, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We also looked at information we held about the provider. This included notifications which are events which happened in the service that the registered provider is required to tell us about.

During our inspection we spoke with the regional manager, a peripatetic manager, two unit managers, a registered nurse, five members of care staff, the chef, two housekeepers, the laundry assistant, the activity coordinator and a volunteer helper. We also spoke with 15 people who lived at the service and four visiting relatives. We also observed staff interacting with people in communal areas, providing care and support. In addition we spoke with one visiting health professional.

We looked at a range of records related to the running of and the quality of the service. These included two

staff recruitment and induction files, staff training information, meeting minutes and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also looked at care plans for ten people, daily care logs for four people and medicine administration records for 20 people.

Good

Is the service safe?

Our findings

People who lived at the service told us that they felt safe living there. One person told us, "I feel very safe and secure in my room." Another person told us how security measures in the service made them feel safe and said, "It's safe with the secure windows and fire alarm doors." The relatives we spoke with were also positive about security within the service and one person's relative said, "He's very, very safe. The layout is ideal, so there is always someone [staff] going past watching him."

The provider had policies and procedures in place to support staff to prevent people from avoidable harm, potential abuse and to help keep them safe. All the staff we spoke with told us that they had received training on how to keep people safe and were aware of the signs of abuse and knew how to escalate their concerns. For example one member of care staff told us that they were confident that the unit manager would take appropriate action in response to any concerns they may have. Furthermore, a registered nurse explained that they would report any concerns to the local safeguarding authority and that the telephone numbers were accessible.

There were systems in place to support staff when the registered manager and unit managers were not on duty. Staff had access to an emergency folder that contained contingency plans to be actioned in an emergency situation such as a fire or electrical failure. Staff had also had access to on-call senior staff out of hours for support and guidance. Furthermore, people had an up to date individual emergency evacuation plan to be used to help them leave the premises safely in an emergency situation, such as a fire.

People did not always have their risk of harm assessed. We found that a range of risk assessments had been completed for each person for different aspects of their care such as their mobility, tissue viability, choking and nutrition. Care plans were in place to enable staff to reduce the risk and maintain a person's safety. We saw that individual risk assessments were reviewed monthly. However not all aspects of care were risk assessed. Staff told us that they did not have enough hoist slings to enable them to provide people with their own sling. Therefore, people had to share the hoist slings with others and this imposed a risk of cross contamination form person to person.

We looked at two staff files and saw that there were robust recruitment processes in place that ensured all necessary safety checks were completed to make certain that a prospective staff member was suitable before they were appointed to post.

We received mixed feedback from people and their relatives when we spoke with them about safe staffing levels. One person said, "I feel very safe as there are plenty of people [staff] around." Another person said, "It seems to be okay, I think." Whereas relatives were not so positive and one said, "There aren't always enough on. They're often pushed for time and at weekends particularly." Another person's relative told us, "The staff ratio comes and goes. They make a huge effort to manage. They are a good team." However, when we shared their mixed comments with the senior managers we found that there were sufficient staff on duty. Staffing levels and skill mix were determined by the care dependency of the people who lived at the service, using a nationally recognised safe staffing tool. We looked at the duty rotas for both units over the Christmas

and New Year period and found that there were sufficient staff rostered to work to meet people's care needs. We noted that when a member of staff reported unfit to work, that another member of staff would cover their shift. Staff told us that when they were unable to cover staff shortages internally that they would contact the on-call manager to approve the use of agency staff.

People received their medicine from staff who had received training in medicines management and staff had an annual assessment to ensure they were competent to administer medicines. When we observed medicines being administered to people, we noted that appropriate safety checks were carried out and the member of staff remained with the person until they had taken their medicine before their administration record was completed. A member of staff told us about the safety checks they had and said, "I have monthly supervision for medicines and my unit manager goes round with us and watches that we make all the checks on the MAR [medicine administration record] chart and talk with the person."

We looked at medicine administration records (MAR) for 20 people and found that medicines had been given consistently and with the exception of one occasion there were no gaps in the MAR charts. We discussed this omission with the unit manager and senior carer. They informed us that the medicine had been removed from the blister pack, but the member of staff responsible had not signed the MAR chart and it remained unclear if the person had received their prescribed medicine. The incident was being investigated internally at the time of our inspection.

When medicines were prescribed to be given only when a person needed them we noted that some protocols were in place that provided additional information and guidance about when and how to administer them. However, we did not see protocols with the MAR charts for an inhaler, an anti-sickness medicine and for a strong pain killer. This meant that staff did not have guidance on the safe administration of these medicines and this put people at risk of harm.

Each MAR chart had a photograph of the person for identification purposes and any allergies and special instructions were recorded. When a person was prescribed medicine through a skin patch, a body map was in place and identified the areas where the patch was to be applied, to minimise the risk of damage to the person's skin. One person who received pain relief from a skin patch told us that they were pain free and said, "It works."

All medicines were stored accordance with legal requirements, such as locked cupboards, medicines trolleys and fridges. There were processes in place for the ordering and supply of people's medicines to ensure they were received in a timely manner and out of date and unwanted medicines were returned promptly. Staff had access to guidance on the safe use of medicines and the medicines policy.

We saw that the service was clean throughout and there were no offensive smells or odours. Staff has access to policies and procedures on cleanliness and the control of infection. We spoke with a housekeeping assistant who showed us the sluice. We saw that cleaning equipment and materials were stored safely. The laundry was clean and tidy and there was a flow through of dirty and clean laundry. Staff had access to hand washing facilities and personal protective equipment in all areas of the service and we saw these used in practice.

We spoke with a senior housekeeper who showed us cleaning schedules which recorded that all rooms were cleaned on a daily basis. There was a monthly deep cleaning schedule for all areas and carpets in communal areas were shampooed at least once a month. When a new member of housekeeping staff was appointed they worked with a senior housekeeper to ensure they were clear about the requirements before they carried out any duties independently.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the knowledge and skills to carry out their roles and responsibilities. We received comments such as, "I see them very busy, but they seem to know the job well, and, "I have high regard for them all. I know them as individuals now and they work as a team" and "They are excellent." We observed that several people were dependent on staff to assist them to transfer from their bed to their wheelchair with the use of a mechanical hoist. One person spoke of their dependence on staff and said, "They have to hoist me into my wheelchair but they do it safely."

Staff were provided with mandatory training such as moving and handling and infection control and we found that all staff were up to date with this. In addition, staff received training that was pertinent to the individual needs of the people in their care. For example, caring for a person with an indwelling urinary catheter, the precautions to take when a person was receiving oxygen therapy or the special care requirements for a person receiving their nutrition through percutaneous endoscopic gastrostomy (PEG). A PEG is medical procedure in which a tube is passed into the person's stomach through the abdominal wall, most commonly used to provide a means of feeding when their oral intake is compromised due to swallowing difficulties. The service had a training room with a human skeleton and hospital type bed. Staff received training on a different topic every month. The current topic was the care of a person living with multiple sclerosis and staff had access to up to date guidance and research on the topic.

Some care staff told us that they were not always prepared to look after a person who presented with challenging behaviours and felt that they needed further training in this area. Staff said that they were unsupported when trying to provide care to people who were resistant to personal care. One member of staff said that when they expressed their concerns to the unit manager about people being aggressive towards when attending to their personal care needs they were told, "You shouldn't get so close" or it was "part of looking after people with dementia." Care staff told us that they were advised to record these incidents on a special chart and added, "No one reads half of it or does anything about it." Therefore staff continued to work without the support and skills they needed to look after some of the people in their care. A registered nurse supported their comments and said, "Some care staff have a limited understanding of mental capacity issues and do not feel they are equipped for caring for people with challenging behaviour."

The provider had introduced a new extended role for senior staff called Care Coaches. Care Coaches undertook specific training to enable them to mentor and support new staff who were undertaking the care certificate. The care certificate is a training scheme supported by the government to give staff the skills needed to care for people.

In addition, the provider had signed up to a new national initiative called Care Home Assistant Practitioner (CHAP) role. We found that the role of CHAPs reflected the changing care needs of people who lived in the service and staff had been given the opportunity to take on more responsibility and develop their skills and careers. For example, some CHAPs had taken on roles historically carried out by registered nurses, such as taking blood samples.

We saw that some staff had been nominated as lead person for key topics. For example, one staff member was the link nurse for infection control and attended regular peer group meeting arranged by the local authority. They then supported other staff to maintain safe infection prevention and control practices.

Staff received regular supervision and appraisals and said that they were a positive experience. We saw that in addition to individual supervision sessions that staff also attended group sessions when an incident needed to be shared, and lessons learnt.

We observed that people's consent to care and treatment was sought by staff. For example, we saw that people had given their signed consent to receive their annual flu vaccination and also when bed rails and wheelchair lap belts had been used.

Where a person lacked capacity to give their consent staff followed the principles of the Mental Capacity Act 2005 (MCA). The 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. To support staff to follow best practice guidance each person had a care plan entitled, "Rights, Consent and Capacity" and these provided information about the person's ability to make decisions for themselves and identified the support needs of people to enable them to maximise their participation in decisions and how the person communicate their views when they could not communicate verbally. For example one person's care plan explained the person used hand gestures and head movements to communicate. We saw that mental capacity assessments had been completed when people could not make some decisions for themselves.

We saw where a person had lacked capacity to consent to their care that they had appointed a member of their family to act as their Lasting Power of Attorney (LPA). A LPA is someone registered with the Office of the Public Guardian to make decisions on behalf of a person who is unable to do so themselves.

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 service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that the provider had followed the requirements in the DoLS and four applications had been submitted to the local authority and were approved. Furthermore, we saw that the provider had complied with the conditions of the DoLS.

We looked at the documentation for mental capacity and consent and saw that this was completed correctly and staff had followed current best practice guidance. We saw where one person was assessed as having capacity that staff had recorded that they were confused or forgetful at times, but this did not affect their ability to make day to day decisions about their care. Overall, the provider had properly trained and prepared their staff in understanding the requirements of the MCA and DoLS.

The provider had recently adopted a menu and recipe system produced by an external catering agency. The rationale behind this was that a four week seasonal menu was in place that ensured that people received a balanced and nutritious diet and that any allergies and special dietary needs were catered for. However, the downside of this system was that there was no evidence that people had been involved in menu planning or that their food preferences were taken into consideration. We received mixed feedback from people on the

quality and choice of food. One person shared their thoughts on the menus with us said, "The food is alright but there are none of my favourites on the menu." They also told us that they had not been asked to put forward suggestions for the menus. Another person said, "The food is not bad, but there isn't much choice. People just leave their food if they don't like it. We are paying for this service and we should get quality food. It's very repetitive" This person told us that they had lost weight and were prescribed supplement drinks to help build them up again. However, other people and their relatives spoke positively about the meals provided and we heard comments such as, "He finds the food brilliant," and "I enjoy the meals. I like Friday fish and chips best. I get seconds of chips."

We read comments people had made in the mealtime feedback book and saw recorded that people would receive a response to their comments from the chef or home manger. Most comments we read for the previous four weeks were negative, and they had not been responded to. People had raised concerns about the frequency of chips on the menu, that treacle sponge topping was dry and that the menu was not suitable for people on a weight reduction diet. We shared their concerns with the senior management team.

We spoke with a recently appointed chef who told us they were unable to add anything new to the menu and this meant that they were limited to the two main course choices available at lunchtime. We noted that a nutritional profile for each person was maintained by the catering staff and they were able to meet individual special dietary needs and also fortified some dishes to support people who may be at risk of weight loss. People had their risk of weight loss and malnutrition assessed, and staff maintained food intake charts when the need arose. In addition, staff worked in partnership with a person's GP and dietician if they required food supplements and these were recorded on the person's medicine administration chart. When a person required their nutrition through a PEG feed this was specially prescribed and monitored by their dietician.

People chose from the menu for the lunchtime meal the night before and we were told this was necessary in order to ensure the correct number of meals for each of the two choices were prepared. However, some staff told us that this was impractical as some people could not remember what they had ordered or would change their mind the following day. Therefore, we discussed the new menu system with the senior management team. They explained that it was early days, but they would review the process and make it more person centred. For example, they planned to introduce picture menus to enable people with memory difficulties to make their menu choice prior to lunchtime food service.

People were supported to maintain good health. We saw that people had access to healthcare services such as their GP, dietician, dentist and speech and language therapist. One person told us that when they had recently taken ill that staff responded quickly to get the medical support and treatment they needed and said, "They've been very quick to get the doctor when I'm congested." Another person told us, "They rang 111 when I had a flu thing and they recommended antibiotics and paracetamol." We talked with a visiting healthcare professional that told us staff contacted them appropriately and that staff knew and understood the care needs of people in their care. We found that when it was in the person's best interest that health professionals came to them rather than the person being seen in an outpatient department. For example, one person who was dependent on their walking frame to support their mobility had recently fractured their arm. A physiotherapist visited the person once a week in an environment that was familiar to the person to assist their rehabilitation so as they could safely mobilise with their injured arm.

When a person had an outpatient appointment, a member of staff, a volunteer would accompany them. We talked with a volunteer who provided one to one time for one person. They told us they accompanied the person to their healthcare appointments so that the person had someone present who was familiar to them to improve their outpatient experience.

Good

Is the service caring?

Our findings

People told us that they were looked after by kind, caring and compassionate staff. One person said, "All of them [care staff] are kind and nothing is too much trouble." Another person told us, "They [care staff] are very patient and I like them." We observed staff interacting with people in groups in communal areas and with people in their own bedrooms. We saw that staff spoke to people with kindness, in a friendly manner and with genuine warmth. One member of staff said, "They [people who lived at the service] love a chat and a sing song. It costs nothing to be happy and smile."

One person's relative told us that staff involved them in some aspects of their loved one's care and said, "She gets hoisted but I have no concerns. They let me help settle her in it [hoist sling] and I reassure her." Several people told us that they were encouraged to maintain their independence. For example we received comments such as, "I feel I can still do what I can," and "I'm an independent sort of guy and won't give in. They let me do whatever I can manage," and also, "They let me wash my hands and face to help."

We found recorded evidence that people and their relatives had been involved in developing their care plans and we found that they were tailored to meet their individual needs and preferences. In addition, we saw that people were encouraged to take part in regular monthly reviews of their care plans. The relative of one person who was unable to speak out for themselves told us, "I did all the paperwork and questions when he was admitted. The office can contact me at any time [for information]."

Where a person was unable to communicate their needs verbally they had a communication care plan with special instructions on the best way to support them to effectively communicate their needs and enable their understanding of what was being said to them. We spoke with one person who was unable to communicate verbally. They had a hand held computer that they used to communicate with others and pointed to pictures on their screen to convey their needs or respond to questions. Two relatives told us that although their loved ones could not communicate verbally that staff respected them as individuals and one person's relative said, "They are very polite with her and ask her [for her consent before assisting her] even though she cannot reply." Another relative said, "They use her name and talk to her while helping, even though she can't reply." In contrast, we observed a registered nurse attend to one person's PEG feed. The registered nurse did not acknowledge or speak with the person during the process.

People were provided with information on how to access an advocate to support them through complex decision making, such as moving into supported living in the community. We saw where a person had an advocate appointed that their contact details where recorded in the person's care file in case they wished to contact them. Advocacy services are independent of the service and local authority and can support people to make and communicate their wishes.

In order to support continuity of care across different care settings people had an "emergency" grab sheet that went with them if they were admitted to hospital or if the service was evacuated in an emergency. The grab sheet provided hospital staff with information that the person may not be unable to share with them. For example, information about their general health, medicines and family contacts.

We saw that people's right to their privacy and personal space was respected. For example, we noted that staff always knocked on a person's bedroom door before entering and doors and curtains were closed when a person was receiving personal care. People confirmed our observations and one person said, "They tap and come in. I get my curtains and door shut if I'm being changed." Another person told us, "They always knock [on the door] and ask if it's convenient." Staff we spoke with told us the steps they would take to ensure a person's privacy and dignity. One staff member said, "We wouldn't talk about other residents in front of them." Staff in each area were supported by a dignity champion.

On Woodview we observed that care staff took a dignified approach at lunchtime. Dining tables were set with linen cloths and napkins and there was gentle music playing in the background. We found that when a person had their meals pureed that all food ingredients were presented separately and their meal looked appetising. We observed two members of care staff sat with people in the dining room at lunchtime to prompt and assist people to eat their meal in an unhurried way. Overall, lunchtime was a positive experience.

Good

Is the service responsive?

Our findings

We found that people were encouraged to spend their time how and where they wished. We saw that some people chose to sit in one of the lounge areas or the activity room, whereas others preferred to remain in their bedroom. One person told us, "Sometimes I go in the lounge or dining room or I may decide to stay in my room. I'm able to decide things for myself." Some people invited us to look at their bedroom. We found that they were supported to personalise their bedroom with items from home such as pieces of furniture, photographs and keepsakes. One person told us, "I was able to choose my room and decide where my TV should be placed." Most people had a document called "My Choices" which provided staff with information about their interests and hobbies that they enjoyed and some background information about their life history.

People had their care needs assessed before and after their admission to the service and personalised care plans were introduced to outline the individual care and support that they needed. For example, one person with a wound to their skin had a care plan which gave information on their dressing regime and the advice provided by their tissue viability nurse specialist. Furthermore, we saw that individual care plans focussed on supporting a person to live well with their medical condition or physical disability and maintain their independence. For example, we spoke with one person's relatives who told us that their loved one's mobility needs changed depending on the environment they were in or the activity to be undertaken and said, "He uses a frame to walk, but is a bit wobbly, so we use a wheelchair when we have to take him out for appointments." We were introduced to one person who could easily become agitated if they had nothing to occupy them. We saw that this person had a "twiddle blanket". The twiddle blanket was a colourful knitted square with different tactile items sewn into it, such as buttons, zips and ribbons, which helped the person remain relaxed and content.

People spoke positively about the care they received. We noted that that their care was individual to them and met their needs and preferences. For example one person said, "They [member of staff] ask me if I want a shower but I can decline if I don't feel up to it. I strip wash myself instead. They change my bed most days and the laundry is good. They help me shave as it's difficult for me, but not every day. I'd rather it wasn't done daily so I ask when I want it done." Other people told us how they planned their day and how staff supported them to do so. For example one person said, "I tell the staff when I want to be in bed, then I watch TV. I wake up when I want, about 6.30am. Then they'll [care staff] get me up. I choose my clothes and where I want to have breakfast."

However, care staff on Woodview told us that were not always able to provide some people with appropriate care in response to their needs. For example, they had two small shower chairs that were suitable for use by people who were independent and had a good sitting balance. However, they did not have an appropriate equipment to bathe people with more complex needs. As a result, one person who had lived at the service for three months had not had a bath or shower since admission. Staff told us that a suitable bathing chair had been broken for some time. We shared this concern with the senior management team who confirmed that replacement equipment had been ordered.

Some people told us how they like to spend their time outside the service. One person told us how they liked to pass their time and said, "I have my car here and can go out for a drive and pick up the post from my house. Someone comes with me in my car." Another person told us how they enjoyed the freedom to access the grounds and said, "I've got my electric wheelchair so can go round the building and in the garden." In addition, people were supported to maintain their links with the local community. For example, one person enjoyed visits to a nearby town and travelled there independently by public transport the previous week. Another person told us that although they lived in a care service, they still drove their car and often went for outings.

People were supported to take part in group activities or one to one activities. For example, we saw several people taking part in a quiz. The interaction between the activity coordinator, care staff and the people taking part was good. Some male residents told us that they were looking forward to their weekly gentleman's domino club held on a Wednesday. We observed some people enjoyed the comfort that having pets brought to them. The service had two guinea pigs and a cat. We saw art work on display in the corridors and we noted that these had been painted by one person who received one to one support for art therapy. We also saw that people had access to a computer and were enabled to use social media to keep in contact with family and friends. One person told us, "I'm very content. There are always things to do."

People had access to information on how to make a complaint, raise a concern or offer a compliment. Most people told us that they had no reason to complain and could talk with staff at any time. We heard comments such as, "I'm definitely happy" and "I have no worries at all." One person shared with us how speaking out about an aspect of their care led to improvement and said, "I used to be unhappy about being washed and dressed while on the commode. Now I go on the bed to sit and get dressed. I insist, so they listen. I'd complain to the manager if I had a big worry." Families told that they would approach a senior member of staff if they needed to complain. One person's relative said, "We just have minor niggles that get rectified immediately." However, another person's relatives told us, "We feel like we are always complaining." They then shared their concerns with us. We discussed their concerns with the senior management team who told us that they were aware of the relative's concerns, had met with them and their concerns were being addressed. Staff told us that if a person complained to them they would escalate the concern to the unit manager or the registered nurse on duty. One registered nurse told us that they would try to resolve the issue at the time, but would always inform the registered manager or the unit manager of the complaint.

People and their relatives were invited to regular meetings and could input to the agenda. However, we found that several did not have a need or wish to attend. For example one person who lived at the service told us, "They do have a talk now and then, but I don't go." One person's relatives said, "I see the notice boards [for news stories and events], but I've not been to the meetings due to the timing. But I can ask anything if I want at any time." Another person's relative said, "I get invitations to meetings, but it's not for me." We read the minutes recorded from the meeting held on 8 February 2017 and saw people had given positive feedback on organised activities such as the domino club, weekly group meetings, quizzes and reminiscence sessions. In addition, we saw that people had requested trips to the local pub, coffee mornings and fish and chip suppers. There was also an opportunity for people and their family or friends to air their views in private. This was called the "resident and guest" meeting. A senior member of staff told us that it was an opportunity for people to get things off their chest. People and their relatives also provided feedback through questionnaires. We saw that feedback on comments and suggestions made by people who lived at the service were on display at the main entrance.

The senior team told us that cooked breakfasts had been introduced as a result of feedback from people using the service. Staff told that this was a popular choice and people welcomed the change made to the

breakfast menu. We saw that the choices available were written on little chalk boards on each breakfast table.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the registered manager had not been at work for several months and the unit managers for Greenwood and Woodview were supported by a peripatetic relief member for two or three days each week. Despite this support, the prolonged absence of the registered manager had a negative impact on leadership in the service. For example, we received mixed feedback from staff about the level of support they received from the unit managers in the absence of the registered manager. Some staff told us that they were unsure who they should approach as one of the unit manager's did not always listen to their concerns. They also felt that some of the issues raised were outside the unit manager's remit. Other staff told us that they were unhappy that the registered manager had been off work for a long time as there was no visible leadership. We brought their concerns to the attention of the senior management team, who said they would investigate their concerns.

A programme of regular audit was in place that covered key areas such as health and safety and infection control. Action plans with realistic time scales were produced to address any areas in need of improvement. The audit outcomes and required actions were shared with staff. The unit managers told us that they did a daily walkabout and spot checks that the bedrooms were clean and appropriate mattresses were in use. In addition, they undertook weekly medicine and care plan audits. However, the problems we have reported on such as a person being unable to have a bath for three months had not been identified in the audits. Therefore no action had been taken to resolve the issues until we raised them with the senior management team.

All staff groups attended regular meetings with the registered manager or a member of the senior management team [in their absence]. We saw that topics discussed were pertinent to their roles. For example, the registered nurses discussed record keeping and their monthly supervision sessions at their previous meeting held on 31 January 2017. We saw that suggestions made at staff meetings were acted upon. For example, staff had access to an inflatable bowl to use when washing a person's hair who was cared for in bed. In addition, staff opinion for improvements in the service was sought through a "colleague engagement survey". Staff fed-back on issues such as communication, professional development and well-being.

Staff told us that they were a good team and that they were proud to work in the service. One staff member said, "We are a good team. Everybody works hard." A team leader praised their team and said, "My team are fantastic."

Staff had access to policies and procedures on a range of topics relevant to their roles. For example, we saw policies on safeguarding and infection control and guidance on delivering personal care. The policies reflected national guidance and legislation and were cross referenced to other policies. For example, the Deprivation of Liberty Safeguards policy was crossed referenced to the Human Rights policy. Staff were aware of the whistle blowing policy, knew where to find it and knew how to raise concerns about the care people received with the registered manager. We found that recent safeguarding concerns had been investigated by the registered manager and appropriate actions had been taken.

The provider acknowledged when staff had made a positive contribution to the service and held an annual awards evening. One CHAPS was nominated for the Values Champion award and was runner up.