HICA

Woodlands - Care Home

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

This inspection was carried out on the 11 September 2017 and was unannounced.

Woodlands Care Home is part of the HICA group of homes. It is purpose built. It provides accommodation for up to 54 people some of whom may be living with dementia. At the time of this inspection there were 44 people living at the home and receiving a service.

The home is situated on the outskirts of Driffield, within walking distance of local community facilities. There are 46 bedrooms for single occupancy (15 with en-suite toilet and wash hand basin facilities) and four bedrooms for double occupancy with wash hand basin facilities. Bathrooms and toilets are shared. There is a lift to the upper floor. There are various communal areas including lounges and dining rooms for people to use. People have access to outside gardens and seating areas, which are provided in secure settings. There is car parking for staff and visitors to the front and side of the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager will be referred to as 'manager' throughout the report.

At the last inspection in November 2016 the overall rating for the service was Requires Improvement. This was because the provider was in breach of two Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in Regulation 11 Need for consent, and Regulation 17 Good governance. We asked the provider to submit an action plan regarding the breaches identified. During this inspection we checked and found the actions were met and no further breaches were identified.

People were protected from the risk of harm or abuse because there were effective systems in place to manage any safeguarding concerns. Care workers were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

The service was working within the principles of the Mental Capacity Act 2005 (MCA). Care workers understood their responsibilities under the MCA and were actively promoting people's independence. The manager and care workers had an understanding of Deprivation of Liberty Safeguards. They had made appropriate referrals to the relevant authorities to ensure people's rights were protected.

Further work was being completed by the provider to ensure that, where a relative had told the service they had a Lasting Power of Attorney, this was validated and the scope of the decision making was recorded.

Care workers were only recruited after checks had been completed to ensure they were of suitable character

to work with vulnerable people. A staff dependency tool was used to ensure sufficient skilled care workers were employed to meet people's needs. On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs.

Support plans were person centred and reflected individual's preferences. Information recorded was reviewed and evaluated as a minimum every month and more often where people's needs changed. This meant care workers had access to up to date records that were reflective of people's current needs.

Assessments of risk were carried out to ensure any care and support activities were safe and with minimal restrictions. Assessments were carried out around the home environment to ensure it was safe for everybody. Where any concerns were highlighted action plans were implemented and reviewed for their effectiveness.

Care workers were supported to complete training, learning and development that enabled them to fulfil the requirements of their role and meet people's individual needs and support their preferences. The provider was improving staff records to ensure they were up to date and accessible.

People benefited from an enthusiastic activities coordinator who supported people to pursue interests and activities of their choosing. Activities were provided on a group basis or one to one depending on people's preferences. People could participate as much or as little as they choose to.

People had access to a healthy variety of food and drink. We received mixed feedback regarding the meal time arrangements. The provider was taking action to address the concerns raised and discussed plans to employ a chef and cook meals in the home.

People had access to a range of health professionals who they could visit or who visited the home to provide care and support to maintain people's health and wellbeing.

The provider completed quality assurance checks that included regular audits of service delivery, activities of care and support and checks on the home environment. We identified some areas that required further improvement. The provider was aware of concerns we raised and had an action plan in place to ensure the home was appropriately maintained for everybody.

Everybody spoke positively about the manager and the deputy. The manager had a clear understanding of their role and responsibilities with regards to their registration with the CQC. The provider, manager and staff were committed and enthusiastic about providing a person centred service for people.

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.

Care workers had received training on safeguarding adults from abuse and understood their responsibility to report any incidents.

There were sufficient numbers of suitably trained and qualified care workers on duty to meet people's individual needs.

People received their medicines safely in line with their prescription.

Is the service effective?

Good

The service was Effective.

The provider was following the legal framework of the Mental Capacity Act 2005.

Care workers were fully supported to ensure they had the skills required to carry out their role and responsibilities.

People received a choice of nutritious food. However, people provided mixed responses regarding the meal time arrangements and the manager was addressing those concerns.

Is the service caring?

Good

The service was Caring

Care workers ensured people's dignity was respected and understood the importance of maintaining people's confidentiality.

People's wishes and preferences to their end of life treatment had been recorded where they had agreed to this.

Care workers had completed training in equality and diversity and the provider ensured they adhered to policy and procedure to treat everybody without discrimination.

Is the service responsive?

Good

The service was Responsive.

People had been consulted about their care and support and records included up to date information that was centred on the individual.

People were supported to enjoy activities and interests of their choosing; to live a full life.

The provider had information for people to follow to make a complaint and they were supported to do this if required. Any complaints were taken seriously and fully investigated.

Is the service well-led?

Good

The service was Well-led

The provider completed regular checks around the home and on the service to ensure standards were maintained or improved where this was required.

Areas that we identified required improvement had action plans in place to ensure completion.

Everybody spoke highly of the management and the support they received.

Woodlands - Care Home

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 registered 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.

This inspection took place on 11 September 2017 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector, one bank inspector, an inspection manager and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before the inspection, we looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. As part of the inspection process we contacted the local authority for their feedback.

We asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

At this inspection we spoke with the manager, the deputy manager and the quality assurance manager. We spoke with five care workers and the activities co-coordinator. We spoke with 19 people and six relatives who were visiting people at the home.

We observed interactions between people, relatives and care workers in the communal areas and during mealtimes. We looked at how the provider managed and administered people's medicines and we observed a medication round.

We spent time in the office looking at records associated with the running and management of the home. We looked at individual care records for five people who lived there and we looked at records on file for four

care workers.

Good

Is the service safe?

Our findings

People who we spoke with told us they felt safe living at the home. People said, "I feel very safe here; safer than I would be if I was at my old home." "Oh yes, I feel very safe here. When I came back from hospital yesterday they [care workers] all came to see me and my tea was here within minutes." "I feel very safe here. I used to run a care home so I know how difficult it can be but it's lovely here. I can't fault it."

People were protected from avoidable harm and abuse. Care workers had received safeguarding training and understood how to escalate any concerns they had. Care workers were aware of the safeguarding policy to prevent and report suspected abuse. A care worker told us, "We report any safeguarding concerns to the local authority and CQC." Care workers also told us they would not hesitate to use the home's whistle blowing policy if they had cause to. The manager showed us how all safeguarding concerns were recorded in a file that included a record of actions taken. The manager said, "We have the safeguarding procedures displayed around the home; care workers are aware of their requirements to report any concerns."

Risk assessments had been completed for any areas that were considered to be of concern. We saw individual risk assessments included skin integrity, mobility, moving and handling and falls for people. Other assessments of risks for the use of equipment for example, bed rails and wheelchairs had been completed and this ensured equipment was safe for people to use. Risk assessments included associated support plans and other records that ensured care and support was provided safely and without undue restrictions in place. Risk assessments were reviewed on a regular basis to ensure they remained relevant and up to date.

There was a contingency plan in place that included advice for care workers on how to deal with emergency situations. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. A PEEP is a record of the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many care workers would be required to assist.

We looked at service certificates to check the premises were being maintained in a safe condition. There were current maintenance certificates in place for the fire alarm system, fire extinguishers, emergency lighting, portable electrical appliances, gas safety and the electrical installation.

There was a fire risk assessment in place. The risk assessment included some recommendations to update the fire alarm system and some smoke detectors. These recommendations were ongoing and had been recorded on three previous occasions. The manager told us the recommendations for improvement to the fire alarm was being looked into by the provider, but assured us the current system was safe. We saw the fire alarm panel was functional with no errors on the system. Fire drills had been carried out on a regular basis to ensure that people who lived at the home and staff knew what action to take in the event of a fire. Records showed that in-house checks of the fire alarm system, emergency lighting and fire doors were completed weekly. The manager showed us a 'Fire Grab Box' that included PEEPs, a mobile phone, a tabard and torches that were considered essential equipment to help with any evacuation in the event of a fire.

The provider used a staff dependency tool to help ensure there were sufficient care workers on duty to meet

people's individual needs. The manager told us, "We employ nine care workers in the morning, eight in the afternoon and four in the evening." Rotas we looked at confirmed these arrangements. At the time of our inspection there were a total of eight care workers on duty. People told us there was enough staff around the home to meet their needs. One person said, "There is always someone about but they seem busy when its bath time. They are always cheerful." Another person told us, "Staff levels are okay and I should know." A relative visiting the home said, "There are enough care staff for my mum but the home could do with more for some of the other people." The manager told us recent recruitment of new care workers had reduced the reliance on agency staff. A care worker said, "We have a good set of staff and people don't have to wait very often to be attended to." Our observations confirmed care workers were situated around the building including communal areas and in areas near to people's own rooms.

We checked the recruitment records for four care workers. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. These checks help employers make safer recruiting decisions and help to prevent unsuitable people from working with vulnerable adults.

Care workers who had responsibility for the administration of medicines had completed appropriate training, and they told us their competency was checked by senior staff. We checked the policies and procedures in place for medicines management and we observed people receiving their medicines over the lunch time period. There was a designated care worker who had responsibility for medicines. We observed they wore a red tabard whilst dispensing medication to avoid being disturbed. The care worker checked the Medication Administration Record (MAR), administered the medication and waited until the person had taken the medicine, assisting where necessary before completing the MAR.

We looked at MAR charts and found that they were clear, complete and accurate. We saw there were protocols in place for the administration of 'as and when required' (PRN) medicines. However, one person received PRN via a transdermal patch applied to their shoulder. The application of the patch required special recording and this had not been completed. We discussed this with the manager and a body map was implemented during our inspection as a best practice approach. The manager told us they would make sure all care workers involved with people's medicines were made aware of this straight away.

We observed that medicines were appropriately ordered, received, recorded, administered and returned when not used. Medicines were supplied by the pharmacy in a monitored dosage system where tablets were stored in separate compartments for administration at a set time of day. Each person had a medicines cabinet in their bedroom for medicines that were applied to the skin, such as creams.

The medicines room included a controlled drugs (CDs) cabinet and we saw CDs were stored securely. CDs are medicines that require specific storage and recording arrangements. We checked a sample of entries in the CD book and the corresponding medicine and saw that these balanced with only one minor error. There was a fridge in the medicines room to hold medicines that needed to be stored at a low temperature. The temperature of the medicine fridge and the medicine room were checked to ensure that medicines were stored at the correct temperature. This meant people's medicines were managed in line with guidance and administered as prescribed.

We observed all care workers using appropriate PPI such as gloves and aprons when dealing with food and providing personal care. The manager had a policy and procedure in place to manage infection control around the home. Training in this area was completed and recorded for all staff as part of their induction programme. Some areas of the home had unpleasant odours and one bathroom required decoration as a

result of water leaks. Staff areas required removal of old furniture and the home required updating and decoration. The manager showed us an action plan in place that had already addressed some concerns and highlighted those we found. The manager told us, "The home is scheduled for a refurbishment which is overdue but we have an agreed action plan in place to make the required improvements." We saw a refurbishment programme was planned. A care worker said, "The environment is a bit shabby but improvements have been made; the garden area was a wilderness but it is now a lovely relaxing place, full of interest for people and great place where residents and staff can sit on a sunny day."

Accidents or incidents involving people who lived at the home were recorded and investigated with outcomes and actions implemented. This information was also recorded on an electronic log so that information could be evaluated centrally by the provider and the health and safety team. This meant any trends could be evaluated and measures implemented to reduce similar events.

Good

Is the service effective?

Our findings

At our previous inspection, completed in November 2016, we found consent to care and treatment was not always sought in line with relevant legislation and guidance. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Need for Consent. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found that the actions had been completed, which meant the provider was no longer in breach of Regulation 11.

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).

Care plans we looked at included a capacity assessment completed by the registered provider. Where people's movement was restricted and they were assessed as not having capacity, applications had been submitted to the local authority for further assessment and approval of a DoLS. At the time of our inspection there were 44 people residing at the home, 26 of whom had been assessed as not having capacity. The provider had submitted an application for a DoLs for those people. 15 people had an approved DoLs in place and 11 were still awaiting a response from the local authority.

A care plan we looked at included an assessment that determined when the person did not have full capacity to make important decisions about their care and support. An application for a DoLS had been submitted. The provider had recorded information that supported and encouraged the person's independence in making every day decisions, for example, choosing which clothes to wear seeing a dentist or GP. Areas of support where the person had been identified as requiring assistance, included hydration and nutritional support. As the person did not have full capacity a best interest decision meeting had been completed and an agreement recorded to put the person on a pureed diet. Monthly reviews were completed to ensure the decisions were still in the person's best interest.

One person received their medication covertly. This meant they did not have the mental capacity to agree to the medication prescribed and this was being administered without their knowledge. We checked their care plan and found there was no best interest decision on record to evidence how the decision had been agreed. There was no information to record when the decision would be reviewed. We spoke with the manager about this who was aware of the person's reduced capacity. They told us, "The person's needs have deteriorated and accordingly their capacity. We need to have a best interest meeting to record that the person's medication is still in their best interest." The manager sent us information to confirm this had been completed after the inspection.

Where best interest meetings were recorded these included consent from representatives appointed with Lasting Power of Attorney (LPOA). A LPOA is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. We saw this information was recorded in people's care plans. Care workers were aware of, and followed this information, for example, when reviewing care plans and seeking support with any decision making on behalf of people. The manager told us further work was planned to ensure care plans accurately recorded where a LPOA had been validated and the scope of the appointee to make decisions on behalf of the person.

Care workers told us and records confirmed they had received training in the MCA. They said, "We always discuss what we are doing with people and ask them if they are happy and agree." "We encourage people to do things for themselves where ever they can and always assume people have capacity to make decisions and to understand what we are asking and why." And, "The legislation for DoLS is a big part of our daily work; there are quite a few people with a DoLS in place because they don't have capacity to make bigger decisions."

People were confident that care workers delivered care that met their needs. People and their relatives provided positive feedback regarding the skills and abilities of the care workers. One person said, "The care workers know my needs and understand how to support me when I need assistance; nothing is too much trouble."

Care workers we spoke with told us they received regular training and that this was managed electronically. A care worker confirmed, "There is always some training; I recently completed safeguarding. We have routine training and when required, we receive training to meet people's individual needs. For example, I have received training on skin integrity, dementia awareness and learning disability. We are well supported." The manager provided us with a training matrix that detailed areas of training completed by care workers that the provider considered to be mandatory.

The provider ensured all care workers received an induction to their role, the service provided and the people who lived there. This included an oversight of policies and procedures, housekeeping and an introduction to peoples' records. The manager told us all new employees completed the care certificate as part of their induction process. Records confirmed this. The care certificate is a set of basic standards in providing care and support for care workers to adhere to in their daily role.

Care workers told us they felt supported in their role and confirmed they received regular supervisions and annual appraisals. A care worker told us, "We receive regular individual and group supervisions; we also receive individual monitoring that helps us to improve our practice where we need to." All the care workers we spoke with confirmed how the support available to them had improved since the new manager had been employed. The manager told us they had completed some annual appraisals for care workers and we saw these in the files we looked at. They said, "We are in the process of updating staff files to make them more organised."

We saw that staff had regular contact with health and social care professionals to discuss any concerns about people's physical or emotional health. These contacts were recorded in people's care plans. People confirmed they could see a doctor when they needed to. Comments included, "Yes the senior rings up for us; I have never had a problem." "If I want one I just ask" "Of course, if I want one I can just say."

People had hospital passports in place. These are documents that people can take with them to hospital appointments and admissions when they are not able to communicate information about their care and support needs to hospital staff.

We looked at meal time arrangements. There were two dining rooms downstairs and one upstairs. We observed the lunch time meal being served. There were sufficient care workers available to serve the food and to help people where they needed assistance. People were offered a choice of hot and cold drinks both during and after their meal. We observed people were offered a choice of food. A care worker crouched down beside each person and spoke to them slowly and clearly and waited patiently for them to reply. People responded with their choice. The staff assisted service users when necessary, showing respect, understanding and maintaining the service users' dignity. The meal smelt appetising and was well presented.

People provided mixed feedback regarding the food at meal times. Comments included, "I had a bacon sandwich for breakfast. The food is okay and we have a choice, but the carrots are as hard as a rock". "Breakfast is very good but the rest is rubbish. I buy my own lunch." "The meat is tough, the potatoes taste of powder. They sometimes do mustard potatoes; that's awful and the veg is sloppy." "I enjoy my food. You can have a full English breakfast if you want." The manager told us that food was prepared externally to the home. The home did not employ a chef and once heated up the food was served to people by staff. The manager said, "We offer people a choice from a four week menu. The food meets nutritional requirements and is healthy for people. However, we have acknowledged from feedback that this is not the service people would like to receive and we have plans to employ a chef and we will cook food in house, in our own kitchens. The kitchen is ready and has been cleaned and is fully functional; we consider this to be a priority area for improvement."

The home was easy to navigate and included picture signs on the walls and doors to assist people with direction and orientation. People could manoeuvre around the home and into the garden easily and access was sufficient for those people who used equipment to have free movement. For example, wheelchairs and walking frames. The manager said, "We have identified that some signs are too high and others need changing where the use of rooms have changed. We have included this in our maintenance programme as part of the overall refurbishment that we have planned." An action plan we looked at confirmed this information.

Good

Is the service caring?

Our findings

People told us they were happy living at the home and that they felt staff cared about them. Their comments included, "Care workers are all lovely." "They are very good and they are very kind and they look after me." "Nothing is too much trouble for them. When you ask them to do something for you, if they can do it, they will." Visiting relatives told us they felt care workers cared about their relatives and supported them to be independent. They said, ''Care workers here obviously have a vocation. They are always kind and friendly and always go the extra mile.'' ''Woodlands may not be the smartest looking of homes but it is the best one we looked at for our relative, who is very content here.''

It was clear that people were treated as individuals and that staff knew people's personality traits including their likes and dislikes. We saw positive interactions throughout the day between people who lived at the home and care workers. People were comfortable in the presence of care workers who we observed were attentive, encouraging and patient.

People assured us that care workers had meaningful relationship with them, that they cared about them and understood their needs and helped them settle in the home and have a fulfilled life. There was a clear, good relationship between people and care workers. It was evident people knew the care workers and the care workers knew people well. Care workers told us, "From speaking with the person and getting to know them I have been able to build a relationship with them. This has helped me to find out the person's likes and dislikes and to encourage them to do things for themselves." "We refer to the daily record and the care plans for obtaining details of each individual person; their needs change daily and the information is usually up to date."

Care plans recorded people's preferred name and we saw that these were used by care workers. We observed that care workers respected privacy by knocking on doors and asking if they could enter the room. A care worker described to us how they protected people's modesty by closing curtains and making sure people knew they were using the bathroom so they were not disturbed. They said, "I would always respect people's wishes and would not make people take a bath if they did not want one; it's their choice. I would just record the outcome to make sure we support people to meet their needs." One person said, "Care workers are very nice, always most respectful when I take a bath."

We asked people how care workers communicated with them and if they received information in a way that was easy to understand. They told us, "I don't always hear very well but they are patient and we have a giggle." "They talk to me about what they are doing and ask me if I agree; they are a good bunch." We observed care workers were aware of people who had hearing and sight problems. People were supported and encouraged to wear their spectacles and hearing aids.

People we spoke with told us family and friends were always made welcome. They said, ''It's a very informal atmosphere here. Visitors can come into the lounge or dining room. They are always made very welcome.'' Relatives confirmed, "They make me feel very welcome". "They keep me informed and seem very caring." The manger confirmed there were no restrictions on visitors to people living at the home. They said, "We

positively encourage friends and relatives to visit and be part of the home and the lives of the people who live here."

Information about advocacy was available for people who lived at the home. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. Some people were supported by an Independent Mental Capacity Advocate (IMCA). IMCAs provide support for people who lack the capacity to make their own decisions and have no one else to represent them.

Care workers recognised the need to maintain people's confidentiality. A care worker said, "I only share information with relevant people on a 'need to know' basis." We saw that records and electronic information about people who lived at the home and staff was stored securely. The manager said, "We are reviewing our archiving as we have information stored [securely] around the home; it is a big job but something we need to action."

Where people had chosen to, their end of life care wishes and any advance decisions were documented in their care plans and kept under review. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate. The manager told us this was a sensitive subject to discuss with people and their relatives but that they were pro-active in recording people's wishes.

Staff had completed training in equality and diversity. We were told that people from all backgrounds were welcome at the service and that steps were taken to ensure that all people were treated with dignity, respect and without discrimination. The provider ensured people's personal beliefs were supported. Care plans recorded any religious beliefs and people we spoke with confirmed they could take part in spiritual activities if they so wished. One person said, "Those of us who wish to, may receive communion every month from the vicar who visit's the home."

Good

Is the service responsive?

Our findings

The provider had developed a personalised approach to responding to people's needs. Before people moved into the home their needs were assessed to ensure the service was suitable for them. Following this initial assessment, individual care plans were developed that provided guidance about how each person would like to receive their care and support, including their preferred routines of care and how they communicated their needs.

Each person's care plan contained a one-page personal profile that included details of their next of kin, other health professionals involved in their care and details of any religious beliefs. Information was also recorded that ensured the person's abilities, wishes and preferences were recorded for daily activities. Examples included, washing and dressing, hair care, foot care, sight, tissue viability, falls history and continence. Information recorded the type of support and how much the person could do independently. Care workers told us, "Care plans include good information about the person. They are discussed with people, their advocates and family to help complete information that is representative of the individual." Records we looked at had been signed by the person where they had capacity to do so to confirm their acceptance and agreement to the content. Where people did not have capacity best interest decisions had been held that included a person's legally appointed representative and advocate where this was required.

Records included monthly reviews that ensured information was person centred, up to date and reflective of people's changing needs. For example, one care plan included a risk assessment that identified the person was at risk of skin tears due to their lack of independent mobility. A support plan was in place that recorded the person required two hourly positional changes. Associated times and position changes had been recorded by care workers. The care plan included a focused review programme where the information was evaluated for its effectiveness and where required adjustments were made. The outcome recorded the care and support was effective to maintain skin condition.

Care workers showed us daily care records that were held in people's rooms. The manager had recently updated this information which included a daily monitoring log, food charts, a skin Integrity chart, topical medication chart and a cleaning schedule. Care workers completed this information daily where required to do so. The manager said, "The daily records enable us to ensure the care and support needed by the person is provided and recorded. We use the information to evaluate how the care and support is working and to ensure people receive care, support and additional interventions appropriate to their needs."

Care records included information on people's interests and hobbies and their preferences. People were provided with choices. One person said, "We can all choose when to go to bed and when we get up." Another person told us, "I can eat where ever I choose to; I can take my meals in the dining room or in my room." The home had different communal areas where people could watch television, socialise, have quiet time, access the garden areas or they could remain in their own private rooms. Two people had small gates fitted to their door ways. One person said, "I like to stay in my room with the door open; the gate prevents anybody from just walking in who I don't want to come in, but I can still see people walking by." We observed everyone had accessible call bells. One person said, "They [care workers] are quick to respond if

we need anything."

People were involved in choosing and decorating their rooms. Peoples rooms that we were invited to look at were bright and well furnished, some people had their own furniture and one had their own refrigerator. A relative said, "We have helped to decorate the room and added personal effects to make it as homely as possible."
The provider had employed an activities coordinator for five days a week. They told us, "I try and work with my colleague so people have activities to participate in every day and not just Monday to Friday." The activities coordinator told us they had completed training in 'Oomph!' and that they used this knowledge to enhance the experiences of people living at the home. 'Oomph!' is an award-winning social enterprise dedicated to enhancing the mental, physical and emotional wellbeing of older adults.

During the inspection we saw people enjoying activities that included both group and individual sessions. We were told that the service tried to offer a variety of activities and this included arts and crafts, pat dogs, zoo labs, monthly entertainers, HICA in bloom and 'Boccia' which is a type of indoor bowls. Some people had a daily newspaper delivered and there were books for people to read on display downstairs.

People told us there was a hairdresser on site. One person said, "I knew the hairdresser before I moved in here; they know how I like my hair doing and we have a good natter." We observed care workers assisted people to maintain their appearance as they had chosen to. We observed one person having a manicure who looked to be thoroughly enjoying the experience.

Records were maintained to record people's activity experiences, if they had participated and if they enjoyed the session. This information was reviewed for effectiveness. The activities coordinator said, "I keep up to date with people's health and wellbeing by reading their care plans and talking to them to discuss how they are feeling." We observed the coordinator had excellent communication skills and everyone responded to everything that they discussed.

People and their relatives we spoke with told us they had not had any reason to make any formal complaints. They said that if they wanted anything changing they spoke with the manager or the deputy. One person said "My biggest complaint is the food, I like home cooked food but we don't get that here." Care workers told us they were mindful of residents' and relatives' expectations. They told us, "We soon get to know if we haven't done something right. We always try and address any concerns as they happen."

The provider had a complaints policy and procedure and this was available for people to use. The manager told us they would support anybody to make a complaint. During our inspection we observed one person talking to the manager. They were unhappy that during a review a care worker had made reference to the person being confused. We observed a lovely rapport between the manager and the person. The manager clearly understood the person's needs and invited them into the office to discuss the concerns which were taken seriously and addressed. We saw complaints were recorded and investigated with clear outcomes and feedback provided. People and their relatives we spoke with told us they would be very happy to share their views with the manager and care workers if they needed to. There was also a record of compliments and thank you cards from people and relatives expressing gratitude for the care provided by the service.

Good

Is the service well-led?

Our findings

At our previous inspection completed in November 2016, we found the provider did not have in place effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying out of the regulated activity. The quality of record keeping at the service was inconsistent. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Good governance. We asked the provider to submit an action plan detailing the actions they intended to take to meet with the breaches we identified. During this inspection we checked and found that the actions had been implemented and improvements made which meant the provider was no longer in breach of Regulation 17.

The provider showed us checks they completed to maintain the quality of the service and to identify any areas where improvement was required. Checks were completed for the environment of the home that included maintenance of equipment, health and safety, fire safety and accidents and incidents and call bell response times. An infection control audit completed in July 2017 evidenced the provider was 96.9% compliant. Other monthly checks had been completed to audit the management of people's medicines, care plans and records associated with people's health and wellbeing. Where audits identified any areas for improvement, these were added to an action plan for review and completion.

Where our inspection identified areas for improvement the manager was responsive to our concerns. The manager had a clear awareness of further improvements that were required and had measures in place to ensure these were recorded for action and reviewed for completion in a timely manner. This included recommended updates to fire prevention and alarm systems, a maintenance programme to renovate the décor in the home, ongoing checks to ensure people's records were up to date, and actions to improve the dining experience for people.

The registered provider utilised an Early Warning Audit Tool (EWAT). This meant a regional director or a manager from another service carried out a quarterly audit to check how the service was performing. This provided comprehensive feedback regarding areas the service needed to improve on and recognition of what they were currently doing well. An associated quality and compliance report for August 2017 resulted in an overall outcome of 87.6%. Any actions included in the report had been signed as completed or included dates by when compliance would be achieved.

The quality assurance systems ensured people were supported to live and enjoy their lives without taking unnecessary risks and without undue restrictions in place.

Everyone we spoke with at the home knew the name of the manager. We were told and we observed the manager had an 'open door' policy and was always approachable. People spoke highly of the manager and felt their best interest was always considered. One person told us, "The manager is very approachable; I have discussed my dissatisfaction with the food arrangements with them but unfortunately I felt their hands were tied by company policy. They were very supportive and I have other arrangements now."

Care workers told us, "There has been a massive improvement over the last 12 months; paperwork has

improved and is up to date and the medication process has improved." "I wouldn't hesitate to raise any concerns." "We seem to be working together better as a team and other care workers are more willing to help each other out now we have a new manager."

Care workers told us that they would have no hesitation in speaking with management and that they were sure if there were issues these would be taken care of. There was clear staffing structure and staff at all levels had a clear understanding of their roles and when to escalate any concerns for higher level investigation. A care worker told us they had raised concerns with the manager using the whistleblowing policy. They said, "My concerns were professionally dealt with and resulted in a positive outcome; I wouldn't hesitate to repeat the process now with this manager."

We asked care workers what they thought the service did well and what they could improve on. They all told us they thought the service was a caring service and that they put people first. In respect to improvement, one care worker could not think of anything, one mentioned how the environment was a bit shabby. However, they said that improvements had been made and described the garden area where people and staff can sit on a sunny day. Another care worker mentioned the daily record folders and said that they were a great idea but that staff needed to have more training to complete them correctly. The manager showed us a daily check list they completed that included bathing charts and food diaries from the daily record files. The manager said, "The daily check lists are quite new and ensure care workers have access to records that highlight any concerns."

The provider ensured information was shared through the home and service with everybody involved. Regular meetings with care workers, managers, domestic staff and kitchen staff were recorded and we saw these provided an opportunity for open dialogue and information sharing. A care worker told us, "We have regular staff meetings. They are a good opportunity to receive news and updates about any changes and they are an opportunity for us to feedback any ideas or concerns."

The provider had sought the views and feedback from people who lived at the home, their relatives and staff via a survey sent out in November 2016. The survey highlighted that 100% of those people who responded and who lived at the home felt the service kept them safe and effectively communicated with them. However, 50% of respondents felt there was sufficient staff to meet their needs. As a result of the survey, the previous manager ensured that agency workers were used whilst actively recruiting for full time care workers to ensure there where correct staffing levels to meet the needs of people. The survey also highlighted that 65% of people felt they were invited to meetings and were encouraged to provide feedback. Because of the feedback the current manager told us they had an action plan in place to ensure regular communication feeds were open for people, staff, and family members to have direct access to both the manager and deputy throughout the year. They told us this ensured feedback was received on a more regular basis and that they were able to identify areas of concern and resolve immediately. This meant the provider sought and acted on feedback to help maintain and improve standards of care and support.