Elderet Limited

Woodbine Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 20 February 2017 and was unannounced.

The inspection was brought forward due to concerns the Commission was notified about in relation to the care and support people received. We had also been informed that the service had experienced another management change. Since September 2015, Woodbine Manor Care Home has had three management changes. At the last inspection in May 2016, the service was meeting the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, but some improvements were still required. We had rated the service as Requires Improvement overall, because although significant improvements had been made to address previous shortfalls raised at the inspection in October 2015, where the service was rated as Inadequate, these improvements were yet to be embedded and sustained.

Woodbine Manor Care Home is registered to provide accommodation and care for up to 29 older people who live with dementia. It is situated in a residential area of Bognor Regis, West Sussex. At the time of this inspection, there were 18 people living at the service. The home is purpose built and accommodation is provided over two floors in single occupancy rooms. A passenger lift provides access between the floors. There is a communal lounge and dining room on the ground floor. On the first floor is another lounge, which is more private and used when the hairdresser visits on a weekly basis. We also observed other seating areas along the hallways where people could rest, where books were available to read and windows where people could sit and look outside. Two resident cats, Daisy and Dylan, were popular with people living at the home.

A new manager was appointed in October 2016. The appointed manager registered with the Care Quality Commission in February 2017. 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 service had been the subject of a safeguarding enquiry by social services following one incident in August 2016. The previous registered manager, current registered manager and staff had worked closely with social services. They had taken steps to make improvements and follow recommendations to enhance the quality and safety of the service. Woodbine Manor was providing a safe service and we observed people receiving support in line with their needs and preferences.

Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and people were encouraged to make decisions about their care and treatment. The provider had installed CCTV in all communal areas but it was not clear what the use of CCTV was trying to achieve and how people had been consulted before and after it was installed. We have made a recommendation in the effective domain about the use of CCTV for surveillance purposes to ensure that it is proportionate, fair and complies with relevant legislation to protect people's rights and privacy.

At the last inspection, the management team had identified the need to improve the standard of care planning within the service. For example, whilst we found that people received appropriate care, this was not always reflected in the care plans, which contained unclear information and guidance to staff. The management team had plans to develop the care plans on a new electronic system, to ensure they were comprehensive and up to date. Following the inspection, the previous registered manager informed us this would be completed by September 2016. At this inspection, whilst we could see that all care plans had now been transferred onto the electronic system, they still contained unclear information and guidance to staff. However, we found that staff demonstrated sound knowledge of people's needs and there was no impact on the care people received. We have written about this further in the well led section of this report.

Although systems for monitoring quality and auditing the service had significantly improved and were being used to continually develop the service, this was still an area of improvement. There was no system in place for auditing care plans. Therefore, the registered manager was not fully aware which care plans needed to be reviewed. The registered manager had also not identified that people's behaviour monitoring charts had not been fully completed and therefore was unable to monitor and effectively mitigate risks relating to people's health, safety and welfare. The registered manager told us they did know this was a gap in recording and was in the process of developing a new auditing tool. However, no target date for implementation was given. The current system to assess, monitor and improve quality and safety of the services provided was not effective to ensure people's needs were properly monitored and reviewed, to inform their care planning. This had been identified as an area for improvement at the October 2015 and May 2016 inspections.

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. The members of the management team and care staff we spoke with had a full and up to date understanding of DoLS. These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. Appropriate DoLS applications had been made, and staff were acting in accordance with DoLS authorisations.

Staff were trained in adult safeguarding procedures and knew what to do if they considered people were at risk of harm or if they needed to report any suspected abuse. People told us they felt safe at the home.

Systems were in place to identify risks and protect people from harm. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required.

Accidents and incidents were accurately recorded and were assessed to identify patterns and trends. Records were detailed and referred to actions taken following accidents and incidents.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

There were sufficient staff to meet people's needs and keep them safe. The registered manager used a dependency tool to determine staffing levels. This information was reviewed following falls or changes in a person's health condition.

Safe staff recruitment procedures ensured only those staff suitable to work in a care setting were employed.

Staff had received a range of training and many had achieved or were working towards a National

Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD) in Health and Social Care. Staff attended regular supervision meetings with the registered manager.

People had sufficient to eat and drink and were offered a choice of food and drinks throughout the day. They had access to a range of healthcare professionals and services.

The home had been decorated and arranged in a way that supported people living with dementia.

Staff were caring, knew people well, and treated people in a dignified and respectful way. Staff acknowledged people's privacy and had developed positive working relationships with people. Relatives spoke positively about the staff at Woodbine Manor Care Home. Staff listened and acted on what people said and there were opportunities for people to contribute to how the service was organised.

A range of activities was planned that met people's interests and facilitated their hobbies. People had access to the community, supported by staff.

Complaints were listened to and managed in line with the provider's policy. Since the last inspection in May 2016, there had been two complaints.

People and their relatives were involved in developing the service through meetings. People, relatives, healthcare professionals connected to the service and staff were asked for their feedback in annual surveys. Staff felt the registered manager was very supportive and said there was an open door policy. Relatives spoke positively about the care their family members received.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Some care plans and risk assessments lacked detail and guidance for staff on how people should be supported safely. However, staff demonstrated a sound understanding of people's needs. We have written about this in the 'Well Led' section of this report.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Medicines were managed in accordance with best-practice guidelines.

Is the service effective?

Requires Improvement

The service was not always effective.

Deprivation of Liberty Safeguards (DoLS) were in place and the principles of the Mental Capacity Act 2005 (MCA) had been followed. However, the provider had recently installed CCTV in communal areas and could not demonstrate that this had been done in consultation with people and its use proportionate to assessed risk.

Staff were trained in a range of topics, which were relevant to the specific needs of people living at the home.

People were supported to maintain good health and had regular contact with health care professionals.

People were provided with a balanced diet and had ready access to food and drinks.

The environment was conducive to meeting the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People were looked after by kind and caring staff. Relatives and people spoke highly of the staff.

People were supported to express their views and to be involved in all aspects of their care. Relatives attended review meetings.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was tailored to their needs. However, this was not always reflected in people's care plans. We have reported on this, in the well led domain.

A programme of activities was organised in line with people's preferences.

People were aware of the complaints procedure and knew what to do if they were dissatisfied.

Is the service well-led?

Requires Improvement

The service was not always well led.

While aspects of the quality assurance audit systems worked well, we found the service lacked appropriate governance and risk management frameworks. This could result in missed opportunities to ensure consistently safe and good quality care and treatment.

The culture of the organisation was open, transparent and inclusive, which enabled staff to raise concerns.

The registered manager sought the views of people, relatives, staff and professionals regarding the quality of the service and to check if improvements needed to be made.

Woodbine Manor 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 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 20 February 2017 and was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by experience at this inspection had experience of dementia and elderly care.

Prior to 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 any improvements they plan to make. We reviewed the PIR and other information we held about the service including previous inspection reports. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection, we observed care provided by staff to people including how medicines were administered to people and the lunchtime experience. We met with eight people living at the service and five relatives. Due to the nature of people's needs, we were not able to ask everyone direct questions. We did however, observe people as they engaged with their day-to-day tasks and activities. We spoke separately with the registered manager, deputy manager also known as 'care manager', four care staff, the chef and three visiting healthcare professionals.

We looked at the electronic care plans and associated records for six people. We reviewed other records,

including the registered manager's internal checks and audits, medication administration records (MAR), health and safety maintenance checks, accident and incidents, compliments and complaints, staff training records and staff rotas. Records for five staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

The service had been the subject of a safeguarding enquiry by social services following one incident in August 2016. The previous registered manager, current registered manager and staff had worked closely with social services. The outcome of the safeguarding enquiry required the provider to ensure all moving and handling training was up to date and ensure staff understood how to use equipment. The provider was to ensure that all staff were trained and that there was a procedure for staff to follow in the event of discovering an unexplained injury. Training records demonstrated that all staff had received these identified areas of training and the staff we spoke with were clear about their responsibilities in regard to these areas to ensure people were supported safely. The provider was also asked to ensure that detailed pre admission assessments were completed and that all care plans and risk assessments would be completed within one week of a person's admission. The registered manager had amended the pre admission assessment to ensure the current needs of a person, their objectives and the proposed care plan. The registered manager explained this enabled staff to have a better understanding of people's needs until a full care plan could be completed. We were satisfied the provider and registered manager had taken steps to make improvements and follow recommendations to enhance the quality and safety of the service. We found that Woodbine Manor was providing a safe service and we observed people receiving support in line with their needs and preferences.

People told us they felt safe. One person said, "I certainly feel safe living here; you only have to look around and see how we all help each other. I have no complaints with the way things are kept. I take medication everyday but I cannot really remember what it is for. The staff keep hold of it and bring it to me when I need it. Certainly if I need anything for pain, the staff are very good and respond quickly, so I'm not in any unnecessary pain. Staff are extremely good and you can talk about your problems with them. No one wanders in to my room as I have a key to my door, so I know my belongings are safe in my room". Another person told us, "It's a lovely home to live in; I have lots of friends here. The staff look after me well, there are certainly enough of them and they change over in the afternoon. If I'm in my room and press my buzzer they come to me quickly".

A visiting relative we spoke with was happy their family member was safe. They told us, "I can't fault the care here at all. I visit whenever I want. The staff gave me the door code so I can just let myself in. There always seem to be plenty of staff around. I know [named family member] is safe here".

Three visiting health care professionals we spoke with on the day of our visit were of the opinion people were safe living at the home. One told us, "I have the door code so I just come in when I need to. I do think people are safe here and well cared for". When asked if they felt the staff provided a safe service to people, another professional said, "I have no problem in that regard. I think the staff are very caring and I've no reason to think they're not well looked after". Another professional said, "The service is nothing like how it used to be, really good improvements have been made. I think people are receiving a safe service, from caring staff who know the people who live here very well."

People were protected from avoidable harm by staff who had been trained to recognise the signs of

potential abuse. We asked staff about their understanding of safeguarding and what action they would take if they suspected abuse was taking place. Without exception, all the staff we spoke with told us they would report any concerns they had to the registered manager. The provider's policy relating to safeguarding procedures was kept in the office and staff told us they would also check with this policy to ensure that appropriate action was taken. One staff member told us, "I would tell the manager if I thought abuse was happening here. If they didn't do anything I would let the CQC know straight away". Another staff member said, "That (abuse) doesn't go on here but if I saw it I would inform the manager. I know they would sort it out".

People's risks were identified, assessed and managed safely. Risk assessments relating to people's mental health, physical health, personal health, moving and handling, behaviour, skin integrity, nutrition and falls had been completed and were stored within people's care plans. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. We looked at risk assessments for six people and these contained advice and guidance for staff on how to manage and mitigate potential risks to people. However, for some people we found examples where, advice and guidance for appropriate responses were sometimes vague. Nevertheless, staff demonstrated sound knowledge of people's needs, and we found this to have no impact on people being supported. We have reported on this, in the well led domain.

Accidents and incidents were also logged and risk assessments reviewed and updated if needed. Senior staff reviewed people's risk assessments on a monthly basis to ensure they were in line with their current needs.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. These checks included the gas heating, electrical wiring, fire safety equipment and alarms, Legionella and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff, in how to support people to evacuate the premises in an emergency.

There were sufficient staff to meet people's needs and keep them safe. The registered manager used a dependency tool to determine the staffing levels needed. This information was reviewed following falls and if a person's health condition was deteriorating, which might increase, or change their dependency level. Rotas confirmed there were sufficient staff to meet people's needs safely. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered. Staff told us, the management team offered support and guidance when needed. The service had a 24 hour on call system in case additional staff were needed. Staff told us there was always enough staff to respond immediately when people required support, which we observed in practice. One staff member told us, "I think there is enough staff. I do get time to talk and spend time with the residents".

In addition to the care staff, the service had a team of cleaning staff, a chef and kitchen assistant and one-activity coordinator. This allowed the care staff to attend to people and their needs.

New staff were recruited safely and records confirmed this. Two references were obtained, identity checks carried out and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers make safer recruitment decisions and help prevent unsuitable staff from working with people.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff did so safely and in line with the prescription instructions. Medication Administration Records (MAR) were in place and had been correctly

completed to demonstrate medicines had been given to people as prescribed. Medicines were locked away as appropriate. All staff were trained to administer medicines. The registered manager completed an observation of staff to ensure they were competent in the administration of medicines. We checked a sample of the medicines and stock levels and found these matched the records kept.

Requires Improvement

Is the service effective?

Our findings

Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Records confirmed that staff had completed training in the MCA and had a good understanding of this topic. For example, staff confirmed that people were enabled to give consent to most decisions concerning their day-to-day support by using communication techniques individual to the person.

In November 2016, the provider had installed CCTV in all communal areas. However, in discussions with the registered manager it was unclear the rationale for this and whether people, their relatives and others had been consulted about its use and purpose. We could not see that the provider and registered manager had considered their compliance with the Data Protection Act 1998, Mental Capacity Act 2005 and Human Rights Act 1998 to ensure people's privacy and the necessity of CCTV. It was unclear what they were trying to achieve by having it in place and whether less restrictive options had been considered. Relatives told us they had once been consulted about the use of CCTV, but that they had heard nothing since it had been put in place. People told us they did not understand why they were being recorded or the purpose of CCTV. We had been informed that a person who had been assessed for a placement at Woodbine Manor had not been informed prior to accepting a placement that there was the use of CCTV in all communal areas. The registered manager acknowledged that any person wanting to reside at Woodbine Manor had the right to know they were going to be recorded and that the footage was being kept for 30 days.
Although the CCTV was voluntarily switched off during the inspection, we were informed after the inspection that the use of CCTV was going to continue following a review of its usage.

We recommend that provider and registered manager seek advice and guidance from a reputable source about the use of CCTV for surveillance purposes to ensure its use is proportionate and fair and complies with relevant legislation. The Commission has also published guidance for providers on the use of CCTV entitled, 'Using Surveillance' which is published on its website.

Appropriate DoLS applications had been made, and staff acted in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary

consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams. We checked people's files in relation to decision making for those who were unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests.

Staff received training in a range of areas, which the registered manager had assigned as mandatory and essential to the job role. This included emergency first aid, moving and handling, fire safety, health and safety, infection control, food hygiene, equality and diversity and safeguarding. In addition to the mandatory training, the registered manager had ensured specialised training was given to care staff to be able to meet the individual needs of people being supported. This included staff completing courses in dementia care, diabetes awareness, distressed signs, reactions and behaviours (Challenging Behaviours), nutrition and hydration, managing dysphagia (difficulty in swallowing), person centred care, wound care and pressure ulcer prevention. We looked at the staff training certificates contained in staff files, which confirmed that staff had received essential training to enable them to support people effectively.

Staff were encouraged to complete various levels of National Vocational Qualifications (NVQ) or more recently Health and Social Care Diplomas (HSCD). These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff that had the knowledge and skills they needed to carry out their roles and responsibilities. One new member of staff told us, "I'm not new to care, just to the home. I had a good induction. I shadowed staff for a few days and had a chance to get to know the residents".

All of the staff we spoke with had received recent, formal supervision or a yearly appraisal. One staff member said, "I do get supervision. It's very good but I know I can approach the manager at any time". Another staff member told us, "I can talk about how it's going and what training I might need. The manager is very open and honest. I've never come across anything like it". Records showed that at the meetings staff discussed their work, training, residents' needs, any problems, staffing and any suggestions for improvements. Records showed the discussions that had taken place, together with a review of actions agreed from previous supervision meetings. Staff also received annual performance reviews. Staff told us that they met together through handovers during the day, staff monthly meetings, residents' monthly meetings and through supervisions with their manager. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us, this worked for their service and that the registered manager had an open door policy where they could talk to them anytime they needed to.

People were supported to have sufficient to eat and drink and to maintain a balanced diet. We talked with the chef who explained how they catered for people's dietary needs. For example, for those who required a soft diet or who lived with diabetes. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. Plate guards were used, where needed, to help people to eat their meal independently. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone first came to live at the home.

We asked people about the food on offer. One person told us, "The food is really good, we have a good choice. The staff are aware of my likes and dislikes, should I not like what's on the menu then I can always have something different. There are snacks throughout the day but I don't tend to have anything other than at meal times". Another person told us, "I enjoy the food, it's lovely. We do get offered something different if we don't like what's on the menu". We observed the lunchtime meal in the dining room. The atmosphere was calm and relaxed and there was music playing which people told us they enjoyed. Tables were nicely laid with tablecloths and condiments. Staff assisted people who required support with eating their meal in a discreet and unhurried way. Fruit and biscuits were always available if people wanted a snack. People's food and fluid intake was routinely monitored, whether or not they were at risk of malnourishment. We observed that drinks were freely available at mealtimes and throughout the day in people's rooms and communal areas.

People were supported to maintain good health and had access to a range of healthcare services and professionals. One person told us, "I think the staff are good they know how to look after us all. If I need to see a Doctor or the Nurse the staff arrange it; I also see a Chiropodist."

We spoke with three visiting health professionals. One told us, "The staff seem very knowledgeable about who they are looking after. They do refer appropriately and will listen to advice given. They can be a bit panicky at first but they do listen and act". Another visiting professional said, "If I talk to staff it's clear they know their residents. If I give advice or guidance, they will follow it". The third health professional told us, "The staff really know the residents well. They pick up quickly if someone they support is unwell and contact the GP appropriately. Calls made have always been appropriate and we now have a good relationship."

Care records documented the involvement of healthcare professionals such as the GP, chiropodist, district nurse or optician. If needed, staff would support people to attend their hospital appointments. Each person had a transfer to hospital file which provided information that would be required if the person needed to be admitted. This helped to make sure that other professionals would have information about people's general health, how they communicated and any specific wishes regarding their healthcare.

The colours and décor of the home supported people living with dementia to orient themselves in their surroundings. For example, there were objects placed around the home for people to pick up and engage with. We observed people walking around with various items that were of interest to them, such as a doll, which some people enjoyed cuddling.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Relatives spoke highly of the staff and how they always showed concern for people's welfare and wellbeing. One relative said, "Well for [named family member] needs it's quite personal, she always looks nice. As best as can be I do believe the staff uphold her dignity, they have to do everything for her. I have seen the staff giving her a little kiss at times, which is such a nice touch. The staff are like a family, very friendly, kind and caring. I am able to visit every day." Another relative told us, "My mum can't do that much for herself now so the staff do most things. They are wonderful, all of them. I can't praise them enough".

We spoke with people about the care they received. One person told us, "The staff are kind and caring; they respect my privacy, knock on my door before entering and treat me well. They help me when I need it and they assist me to have a bath once a week; the rest of the time I am able to wash myself. My friends and family are able to visit whenever they wish and are always made to feel welcome". Another person told us, "The staff treat me well; they are kind and look after me. They wash me, shower me and treat me with respect. They always knock on my door before coming in. The staff know me so well, they know what I like and even how I have my tea and coffee". Another person told us, "The carers are kind. They do not tell you; I mean there are no rules that they put on you. I have no complaints about the staff, they treat us all well. The staff do a good job, they are helpful and always there for you".

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

People were supported to express their views and to be actively involved in making decisions about their care, treatment and support. The majority of people were unable to be fully involved as many lacked understanding in day-to-day decisions about their care and treatment. For these people, the registered manager asked relatives whether they wished to be involved in decisions about their family member's care and how often they would like review meetings to take place. Relatives said they were involved in reviewing care plans. This helped to ensure people's views and wishes were known.

We observed that people were treated with dignity and respect and that people had the privacy they needed. We observed when staff were delivering personal care, doors were shut and curtains drawn. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. From our observations, it was clear that staff knew people's likes and dislikes extremely well. We observed excellent interaction between people and staff who consistently took care to ask permission before intervening or assisting. There was a high level of engagement between people and staff. For example, we observed staff talking with people throughout the day, about their interests, their health and family visits. Consequently, people, where possible, felt empowered to express their needs and receive appropriate care.

Good

Is the service responsive?

Our findings

At the last inspection, without exception, staff demonstrated a thorough knowledge of people's needs. Each person had a current assessment of their needs and their preferences were documented. However, we found care plans contained unclear and minimal information. We found at this inspection, this was an area still requiring improvement. Without exception staff continued to demonstrate a thorough knowledge of people's needs and that the lack of information in people's care plans had not had an impact on the delivery of care. We have reported on this, in the well led domain.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how people's individual needs could be met. The assessments completed prior to an individual moving into the service formed the basis of each person's care plan.

People received personalised care that was responsive to their needs. Care plans provided basic advice and guidance to staff about people's care and how they wished to be supported. They included information on people's personal care, health care, mobility, social care, communication, religious and cultural preferences, dietary needs and medication. Staff completed daily records for people, which showed what care they had received, whether they had attended any appointments or received visitors, their mood and any activities they had participated in. One person, who was an insulin dependent diabetic, received a daily visit from community nurses who monitored the person's blood sugar levels and administered medication. Staff had also ensured the person had received additional healthcare regarding their diabetes, including yearly retinal scans and regular appointments for foot care with an NHS podiatrist. Care plans were reviewed monthly to ensure they met people's needs and were in line with their preferences. Each person had a one page profile so staff could see at a glance what was important to the person and how best to support them. Information about people's daily routines, likes, dislikes and preferences were contained in their care plans.

We asked staff what they understood by the term 'person centred care'. One staff member told us, "It's putting the resident at the centre of what we do". Another staff member said, "I think it means acknowledging what a person wants and needs".

People's interests had been identified and a range of activities was planned to engage people in line with their preferences. We talked to the activities coordinator, who told us they were responsible for organising the activities based on people's interests. The activities coordinator worked a 35-hour week. When they were not on duty, care staff engaged people with activities based on a list/planner, thus ensuring people had access to activities on a daily basis. There was a full timetable available with dates and times of what activities were available and when. There was also an activities display board in the lounge and two other notice boards with picture cards so everyone was aware of what activities were scheduled. We were told outside entertainers also came into the home, which were booked in advance and included on the timetable. Activities included dementia friendly resources to support people with memory recall. There were memory boxes outside many bedrooms; we were told this was work in progress. The idea was to put things of interest relating to an individual. In their memory box There was a 'crafty corner' just outside the main

lounge. Artwork by people was on display with memorabilia. During our visit, we observed people singing, playing games and reading with staff, people were laughing and told us, they were having fun.

People and relatives were asked for their opinions on their experiences of living at the home. These were sought via satisfaction questionnaires, circulated on an annual basis. We examined eight of the most recently returned. They showed a high degree of satisfaction in all areas, particularly in the quality of care and staff attitudes. The provider also asked the opinions of visiting professionals. Three of the four GP surgeries covering the home responded. We noted all expressed a high degree of satisfaction in the areas examined, such as whether referrals to GPs were appropriate, care staff knowledge and management of medication.

People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the registered manager, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. The registered manager told us, since the last inspection in May 2016, there had been two complaints, both of which were still on-going for valid reasons. One person told us, "I've never needed to make a complaint but if I did I would go to the manager who is very approachable. I do believe if I were to complain it would be looked into and taken seriously." One relative told us, "The manager is very open and honest. I couldn't ask for more".

Requires Improvement

Is the service well-led?

Our findings

There was no system in place for auditing people's care plans and risk assessments. Therefore, the registered manager could not demonstrate that actions had been taken to ensure the quality and safety of the service. However, for the examples given below, the registered manager and staff demonstrated sound knowledge of people's needs, and we found this to have no impact on people being supported.

Examples of where we found information to be lacking in peoples care plans were; risks to people's safety, as a result of people's behaviours, were not always assessed and planned for. For example, two people who used the service frequently displayed episodes of verbal and physical aggression towards other people and staff. The risks associated with these behaviours had not been identified or assessed appropriately and there was a lack of guidance for staff to follow. For two other people, the care plan indicated that staff should document their behaviours on an Antecedent-Behaviour-Consequence (ABC) Chart. This direct observation tool can be used to collect information about the events that are occurring for a person in a particular situation. "A" refers to the antecedent, or the event that precedes behaviour. "B" refers to observed behaviour, and "C" refers to the consequence. We found one entry on the record and no further evidence that these records were being completed. The impact of this means, that the person's behaviours were not being regularly reviewed and analysed to ensure the support from staff was the most appropriate. One person had been assessed as being at low risk of developing pressure sores on 9 January 2017; this had changed to a medium risk by 13 February 2017. There was no indication in the care plan what had changed to cause the increased risk or what was planned to manage the risk and support the person. A care plan for another person, who was living with dementia, stated they would, 'Occasionally show reluctance when staff offered assistance'. This person's care plan lacked information concerning the triggers for this behaviour and the techniques staff should use to diffuse the situation and calm the person's behaviour.

The current system to assess, monitor and improve quality and safety of the services provided was not effective to ensure people's needs were properly monitored and reviewed, to inform their care planning. This had been identified as an area for improvement at the October 2015 and May 2016 inspections. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed these findings with the registered manager at the time of the inspection. The registered manager acknowledged this and told us she was working hard to strengthen the way in which audits were completed. The registered manager stated she was working on a new audit tool; however, an implementation date was not given.

We found other quality assurance systems in place to regularly review the quality of the service that was provided. The registered manager carried these audits out monthly. Accidents and incidents were analysed and any patterns or trends were identified and acted upon. The audit tool included an audit of health and safety, medication, safeguarding, falls and infection control. The audit included staff support and supervision, staff training, staffing levels, staff files and team meeting minutes. Complaints were reviewed, menus checked and minutes of meetings reviewed and acted on. Records demonstrated that information from the audits was used to improve the service. Where issues were found, a clear action plan was

implemented to make improvements. For example, in February 2017, the registered manager identified the medication room door was left open; a sign was put in place as a reminder for staff to lock this door when not in use. In January 2017, the registered manager identified the need to arrange staff supervisions and appraisals.

Since September 2015, Woodbine Manor Care Home has had three management changes. At the last inspection in May 2016, we found that the service was meeting the regulations, but some improvements were still required. We had rated the service as Requires Improvement overall, because, although significant improvements had been made to address previous shortfalls raised at the inspection in October 2015, where the service was rated as Inadequate, these improvements were yet to be embedded and sustained.

At this inspection, we found Woodbine Manor Care Home had the benefit of strong, focused leadership. The registered manager worked five days a week and a deputy manager also known as a 'care manager' supported the registered manager. The registered manager was supported by eight team leaders, who worked varied hours, leading shifts to enable staff to feel more supported and offer guidance. They also took the lead regarding how staff were deployed to meet people's personal care needs. The registered manager said that she had an excellent relationship with the management team and staff at the home. Staff and management commented that they were all comfortable about being able to challenge each other's practice as needed and to drive continuous improvement.

There was an open, positive culture within the home. People, staff and relatives told us Woodbine Manor Care Home had really good leadership. One person told us, "The manager is good, she has a little chit chat when I see her around, she's approachable and I'm able to speak to her when I need to. From what I've seen so far since living here I don't think there is a need to change things, or I don't really see how things could be improved." One staff member told us, "There's been a lot of upheaval, with the change of manager but I think it's settling down now". Another staff member said, "It is well led. The manager is so open and approachable, more than anyone else I've come across".

We asked staff about the vision and values of the service. One staff member said, "I think it's a nice place to live. We try to make it a home from home". Another staff member told us, "It's like a family home I think. We all get on really well together".

The registered manager told us that what they had achieved to date was down to the whole staff team, demonstrating a respect for others' input into the service. There was a culture of continual reflection by the staff and management team. They were passionate and dedicated in their approach to improvement, and a visible presence in the service, accessible at all times by operating an 'open door' policy. We observed this during the day; the registered manager shared an office with all levels of staff, which resulted in a culture of shared learning and information sharing to support the running of the service. For example, staff came in regularly and asked questions, passing on important information about people and their well-being.

Staff meetings were held every month, which gave opportunities for staff to contribute to the running of the home. We saw the meeting minutes and discussions included people who used the service, health and safety, recruitment and staffing. Staff were aware of the whistle blowing procedures should they wish to raise any concerns about others or the organisation.

The views of staff were also sought via questionnaires. Five had been recently returned, all with positive views of working at the home, particularly in training, the management of the home and the supervision process.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to assess, monitor and improve the quality of the service. (2) (a)