Mrs Barbara Rogers

Park Hills Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on the 16, 17 and 23 February 2016. Our visit on 16 February was unannounced.

We last inspected Park Hills Nursing Home in April 2014. At that inspection we found that the service was meeting all the regulations we assessed.

Park Hills Nursing Home is a Victorian house that has been extended to the rear of the building and is situated approximately one mile from Oldham town centre. The service is registered to provide nursing and personal care for up to17 people and specialises in end-of-life nursing care. At the time of our inspection there were 17 people living at the home. In addition, since February 2015 Park Hills Nursing Home is registered to provide personal care to people in their own homes in the community, and currently supports two people in this manner.

When we visited the service a registered manager was in place. 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.'

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

Staff had a good understanding of safeguarding procedures and what action they should take in order to protect vulnerable people in their care. Risk assessments had been completed to show how people should be supported with everyday risks, such as risks to their nutrition or mobility.

Environmental checks of the home, such as of the passenger lift and emergency lighting were up-to-date and the building was well-maintained and decorated.

There were sufficient numbers of appropriately trained staff on duty to care for people, both in the nursing home and in the community.

Recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting with vulnerable people.

Medicines were safely administered by staff who had received appropriate training.

Equipment, such as hoists, bathing aids and pressure relieving mattresses were available in the home and these helped promote people's safety and comfort. The equipment we saw was well-maintained. No equipment was currently needed to support people in their own homes.

Staff had undertaken a variety of training to ensure they had the skills and knowledge required for their roles. Although some staff had not received training in 'safeguarding vulnerable adults' and 'infection control' staff we spoke with had a good understanding about the processes need to protect vulnerable adults from abuse and to prevent the spread of infection in both a residential and community setting.

Staff understood the importance of encouraging people to make choices, where they were able to, and always sought consent before undertaking any care. People we spoke with were happy with the quality and choice of food provided at the home.

People told us the staff were caring and their dignity and privacy were respected. Care plans were 'person-centred' and were reviewed regularly by the trained nurses. Staff cared safely for people with a variety of complex health problems.

The home specialised in 'end of life' care and had taken part in the 'six steps end of life training programme' which provided staff with a deeper understanding of the needs of people approaching the end of their life.

People were supported to maintain good health and where needed specialist healthcare professionals, such as dieticians, were involved with their care. Families were kept informed of any changes to their relatives' health and were invited to comment on the quality of the service through an annual survey.

The service had a complaints procedure in place and people we spoke with in the home and those receiving support in the community felt that any complaints would be dealt with appropriately. People who used the service and staff found the management team approachable and supportive.

Quality assurance processes such as audits were in place to ensure that the service delivered high quality care that met people's assessed needs.

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.

Arrangements were in place to ensure that medication was administered safely.

Staffing levels were sufficient to meet the needs of the people using the service and promote their wellbeing.

Prevention and control of infection were well managed.

Arrangements were in place to safeguard people from harm and abuse.

Recruitment processes were sufficiently robust to protect people who used the service from the risk of unsuitable staff and staff had received training in how to protect people who used the service from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Although care staff demonstrated a good understanding of people's needs we found the supervision they received was not provided frequently enough to help make sure they were supported to carry out their duties effectively.

Staff had received training in a variety of subjects which enabled them carry out their roles effectively, although some staff had not received training in 'Safeguarding Vulnerable Adults' and 'Infection Control'.

People who used the services received the appropriate support from staff to ensure their health and nutritional needs were met.

Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) authorisations were, where appropriate, in place for people. Staff had received training in the MCA; this legislation is designed to protect people who may be unable to make their own decisions.

Is the service caring?

Good

The service was caring.

People were complimentary about the staff and said they were kind and caring. Staff showed warmth and friendship to people using the services and they spoke to people in a kind, comforting and sensitive manner. This helped to make sure people's wellbeing was promoted.

People were encouraged to make choices about their daily life style. People who were able to told us that any information they needed was explained to them clearly by staff who listened and respected them and acted on their views.

People's dignity and privacy were respected. Staff were clear about how to respect people's privacy and dignity, and understood how to put this into practice.

Is the service responsive?

Good

The service was responsive.

Care plans, risk assessments and associated care documents were detailed, personalised and reviewed regularly to help make sure the assessed needs and preferences of people using the service were met.

Systems in place for receiving and responding to concerns and complaints helped to make sure people using the service and their relatives would be confident that if they had any concerns or complaints these would be appropriately addressed and managed satisfactorily.

Is the service well-led?

Good

The service was well-led.

The home had a registered manager who was supported by a management team and registered general nurses and carers.

Staff we spoke with told us the management team were approachable and supportive.

There were systems in place to monitor the quality of care provided by staff.

People using the service and their families were provided with opportunities to express an opinion about how the service was

managed and the quality of service being delivered.

There was evidence available to demonstrate that the service worked in partnership with local health and social care services.

Park Hills Nursing 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.'

The service met the regulations we inspected at our last inspection in April 2014.

The inspection took place on the 16, 17 and 23 February 2016. Our visit on 16 February 2016 was unannounced.

The inspection was carried out by one adult social care inspector. Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us within a required timescale. We also reviewed the inspection report from the previous inspection and contacted the Local Authority (LA) and local NHS Clinical Commissioning Group (CCG) to ask them if they had any concerns about the service, which they did not.

On this occasion we did not ask the provider to complete a provider information return (PIR) before our visit. A PIR is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they are planning to make.

Some of the people living at the home were unable to give their verbal opinion about the care and support they received. Therefore we examined people's care records and observed the care and support being provided to them in communal areas to capture their experiences.

During our inspection of the home we spoke with two people who used the service, four relatives, the management team, including the registered manager, three of the care staff and the cook. We also spoke with one person who was supported by domiciliary carers, and one of their relatives.

We looked around the building, observed how staff cared for and supported people, reviewed records and

looked at other information which helped us assess how people's care needs were met. We spent time observing the lunchtime meal and watched the administration of medication to check that this was done safely.

As part of the inspection we reviewed the care records of three people living in the home, and the records of the two people supported by domiciliary carers. The records included their care plans and risk assessments. We looked at three staff files, which included their recruitment checks and induction and supervision information. We also reviewed other information about the service, such as quality assurance records, staff rotas, complaint and compliment records, and policies and procedures.

Good

Is the service safe?

Our findings

People who used the service told us they felt Parkhills Nursing Home was a safe place in which to live. One visitor said "(the relative) is 100% safe'' and another relative commented ''I feel she is safe''.

The service had a 'Protecting Vulnerable Adults' policy 'and staff received training in safeguarding vulnerable adults during their induction period. Although some staff had not received their annual 'safeguarding adults ' up-date during 2015, the staff we spoke with had a good understanding of safeguarding issues and were able to describe different types of abuse, such as financial, emotional and physical. Information we held about the service indicated any safeguarding matters were effectively managed and reported to the appropriate safeguarding agencies. Staff knew to be vigilant about the possibility of poor practice by their colleagues and knew how to use the home's whistleblowing policy. Whistleblowing is when a person raises a concern about a wrongdoing that may place a person at risk of harm in the workplace.

Staff employed by the service had been through a thorough recruitment process. We inspected three staff personnel files and found that they contained all the relevant documentation, including reference checks and confirmation of identification. All staff had Disclosure and Barring (DBS) criminal record checks in place. These help the service provider to make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions.

We checked with the Nursing and Midwifery Council (NMC) that the registration details of the Registered General Nurses (RGNs) were up-to-date and found that there were no discrepancies. The NMC is the regulator for all nurses and midwives in the UK. When nurses register with the NMC, they are given a personal identification number PIN which is renewed annually.

We reviewed the care files of three people living at the home and saw that risks to people's health, such as poor nutrition and challenging behaviour had been assessed and appropriate information to help staff manage the risks had been written in the care plans. We saw evidence that all risk assessments were reviewed monthly. In addition to health risk assessments, for people receiving domiciliary care, risk assessments had been produced in relation to the safety of the persons home, for example lighting, stairs and potential trip hazards. These helped to make sure the property was a safe environment in which staff could work.

We inspected the home and saw that it was decorated to a high standard and well-maintained. We saw there was a small area of flooring in the bathroom coming loose, which was a potential trip hazard for staff and people who used the service. The registered manager advised us that this would be replaced as soon as possible. We saw that safety checks for the building, such as for the passenger lift, hoists and emergency lighting were all up-to-date.

There were systems in place in the home to protect staff and people who used the service from the risk of fire. Records showed that the fire alarm system had been serviced during 2015, and was tested weekly to ensure it was working correctly. The fire extinguishers were due to be checked in March 2016. There was a

visitors signing-in book in the entrance porch to ensure the evacuation of the correct number of people in the event of an emergency: we saw that this was being completed regularly. People who used the service had a personal evacuation escape plan (PEEP) in place, which explained how each person would be evacuated from the building in the event of an emergency. We saw that these plans were kept in a folder in the hallway to ensure that they were easily accessible. There was a 'business continuity management plan' in place to follow in the event of a major failure of the lighting, heating or water systems.

For those staff carrying out domiciliary visits the service had a 'Lone Working' policy which gave information and guidance on ways in which they could ensure their personal safety while working in the community, such as being aware of their surroundings, and following their designated rota.

People we spoke with felt there were enough staff to meet the needs of the people living at the home and our observations during the inspection confirmed this. We examined the staff rota and saw that the staffing levels on both days of our inspection confirmed the staffing numbers, skill mix and staff qualifications were sufficient as described by the staff and the manager. One person said ''there are always enough staff to help (the relative)''. The registered manager explained that there was always an RGN on duty and that on the whole care staff were allocated to work either on the ground or first floor, so that continuity of care could be maintained. Staff informed the registered manager of their availability to work extra shifts, so that in the event of staff sickness the work could be covered by a regular carer. Agency nurses were occasionally used and the registered manager explained that where possible they requested the same agency nurses so that they would be familiar with the work. A relative we spoke with confirmed that they saw the same agency nurses working at the home.

Domiciliary visits were carried out by two carers, one of whom also worked at the nursing home. This number of staff was sufficient to carry out the current domiciliary work-load, but the registered manager advised us that she would employ more staff if the number of domiciliary visits increased.

The home had an up to date medicines policy and we checked the procedure and systems for the receipt, storage, administration and disposal of medicines. Medicines were stored safely in a treatment room which was clean and tidy and stored the medication trolley and controlled drug (CD) cupboard. The temperature of the room and the medicine fridge were checked daily to ensure that medication was stored at the correct temperature, and our observations of the temperature recording sheet confirmed this. Regular checks on the disposal of drugs, signing of the Medication Administration Sheets (MARs), and medication stock were carried out by the Audit Manager, and we saw written evidence that these had been completed. Medication was only administered by RGNs, who had received appropriate training and completed a workbook on medicine administration to ensure they were competent to administer medicines safely.

The registered manager explained that all the RGNs were trained to administer end of life drugs through a syringe driver and medication through a Percutaneous Gastrostomy Tube (PEG) for those people who could not swallow. A syringe driver is a small portable pump that can be used to give a continuous dose of medication through a syringe. A PEG tube is a feeding tube passed through the abdominal wall into the stomach. We observed the lunchtime medication round and saw medicines were administered safely following the homes policy on the safe administration of medicines. We looked at three MAR sheets and saw that they had been completed correctly and that the writing was neat and legible. Each MAR sheet contained a photograph of the person, which helped minimise the risk of the medication being given to the wrong person. No medication was being administered covertly – this meant giving medicines in a disguised form for example, in food or drink, when a person refuses the treatment necessary for their physical or mental health. One person was receiving support in their own home to ensure that they had taken their medication. A carer visited during the evening to check that the person had correctly taken their medication

from a monitored dosage system (MDS).

We looked around all areas of the home and saw the bedrooms, toilets and bathrooms, communal areas and kitchen were clean and free from unpleasant odours. We saw that food was being stored appropriately and the fridge and freezer temperatures were monitored daily by the cook. These procedures helped to minimise the risk of food contamination. A 'Food Standards Agency' inspection had been carried out in June 2015 and the home had been awarded a rating of 5.

Arrangements were in place for the prevention and control of infection. Although some staff had not received recent infection prevention and control training, staff we spoke to understood the importance of infection control measures, such as the use of personal protective equipment (PPE), including disposable vinyl gloves and plastic aprons. We observed staff using these appropriately, including wearing different coloured aprons for different tasks, such as personal care and food handling. Those staff undertaking domiciliary visits carried a bag containing PPE, which meant this equipment was readily available for their use.

Toilets and bathrooms in the nursing home contained an adequate supply of soap, paper towels, aprons and alcohol hand gel and displayed posters detailing safe hand-washing techniques, which helped to minimise the risk of the spread of infection between staff and people using the service. We spoke with the cleaner who described her daily cleaning regime and confirmed that she followed the national colour coding system for cleaning equipment, which prevents equipment from being used in multiple areas.

Requires Improvement

Is the service effective?

Our findings

From the records we reviewed we saw that not all staff had received supervision of their work in line with the home supervision policy. This stated that staff should receive six supervision sessions per annum, but we saw that some care assistants had not received any supervision during 2015, and none of the RGNs had received supervision during this period. Supervision meetings support and help staff to discuss their progress at work and also discuss any learning and development needs they may have. The staff supervision systems the provider had in place were not used effectively to support, monitor and train staff to carry out their duties safely and effectively. This meant that people using the service were at risk of receiving inappropriate or unsafe care.

This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation s 2014.

We saw that for those staff who had received supervision, this was a thorough process. The deputy manager undertook an observation of the work carried out during a shift, checking all aspects of the carers work, including their standard of uniform, use of PPE, handwashing technique, interaction with people, respect for choice, promotion of dignity and their attitude. After the period of observation, staff were invited to discuss any problems that had been identified and to plan future training.

Newly recruited staff had completed an induction programme which included information about the running of the home, details of the six steps programme, policies and procedures, and information about people who used the service. Following the induction staff were allocated a mentor and undertook four days of 'shadowing', where they worked alongside them, and gained experience of caring for people. All new care staff were enrolled on the 'Care Certificate', a national qualification, which, when completed, demonstrates that they have the skills and knowledge to provide compassionate and high quality care and support.

Staff had received a variety of training which enabled them to carry out their role effectively, including manual handling, basic life support, communication, mental capacity act, end of life care and dementia awareness. In addition, staff received specialist training on the care of peg and tracheostomy tubes. Nine carers were in the process of undertaking a 'principles of end of life care' course and seven staff were allocated to attend a forthcoming dementia workshop at the local hospice at the end of February 2016. From the records reviewed we saw that some people had not received recent training in 'safeguarding vulnerable adults' and 'infection control'. Subsequent to the inspection the registered manager informed us that she had enrolled all staff with the Careskills Academy, a company which provides on-line social care courses, and that all staff would be compliant with 'safeguarding vulnerable adults' and 'infection control' training within two months.

During the inspection we reviewed how staff sought consent from people before they were offered care and support. One carer described how someone's body language could indicate that they had consented to care, if they were unable to communicate verbally. We saw evidence that the need for consent and choice were incorporated into care plans: one care plan said 'explain what is happening, observe for any changes in

facial expression or body language'', and another said ''show (the person) their clothes to see if they want to choose what to wear''.

The Mental Capacity Act (2005) 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 decision, any made on their behalf must be in their best interests and as least restrictive as possible. We saw that the majority of staff had undergone training in the MCA and that mental capacity assessments had been undertaken where appropriate.

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 Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. There were two appropriate DoLS authorisations in place at the time of our inspection.

People's nutritional requirements had been assessed on admission to the home and were reviewed at appropriate intervals. People were weighed and a malnutrition universal screening tool (MUST) score recorded. The MUST score helps to identify adults who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop nutrition care plans. Those people who required nutritional support were under the care of a dietician, and additional advice for those people who were fed through a PEG tube was provided by a nutrition specialist nurse.

People told us they were happy with the quality of food. We spoke with the cook, who had been a member of staff for sixteen years and was proud of the standard of food she provided. She showed us a four-weekly menu plan, which offered people a variety of freshly prepared food. People could have a cooked breakfast if they wished and the main hot meal of the day was served at lunchtime. A lighter meal was served at teatime, followed by a supper of sandwiches and hot drinks. Snacks and drinks were offered between meals, and people could request fresh fruit if they wished. An alternative menu was offered to those people who did not like the food that had been prepared. Information detailing which people needed special diets was kept in the kitchen so that the cook had an accurate record of who required, for example, pureed food.

People who used the service were offered the choice of eating their meal either in their room or in the lounge. Those people who chose to eat in the lounge remained seated in their armchairs for their meal, rather than together at the table. They were provided with a small table from which to eat their meal. One person we spoke to told us how the staff accommodated her wishes to have her meals at a slightly later time than other people, as she did not like to wake early.

Care records we reviewed of people living in the nursing home showed that they had access to a range of other healthcare professionals, such as opticians, podiatrists, physiotherapists and general practitioners. One person told us they had recently been visited by a dentist and another said they had received care from an audiologist. The registered manager commented that they had recently sought advice and support from the local hospice for the prescription of end of life drugs. People's health needs were monitored regularly and any changes acted upon promptly. One person commented that their relative had recently had an eye infection and was referred immediately to an optician.

In the home appropriate equipment, such as hoists, electric beds, pressure relieving mattresses and bathing aids were available to meet people's needs and promote safety and comfort. This equipment was well maintained. Specialist nursing equipment, such as for the management of a tracheostomy tube was kept in the person's room, so that it was easily accessible. A tracheostomy tube is a breathing tube, which is

inserted into the trachea (windpipe) through a surgically- created opening in the neck, to enable a person to breathe. We saw that where someone had this equipment in place it was checked daily to ensure that it was correct, and an information sheet detailing the tube size and emergency management of the tracheostomy tube was clearly displayed in their room. This helped to ensure that the care and management of the tracheostomy tube was carried out safely.

The home had a large lounge which provided a communal living area for people who used the service. In addition, there was a small, quiet room for those who preferred to be without a television. Staff explained that some people chose to remain in their own bedroom rather than joining others in the lounge and other people were too poorly to leave their room. People were encouraged to decorate their bedrooms with personal effects, such as furniture, pictures and photographs to help them feel at home. There was a small garden containing garden furniture where people could sit out and which was accessible to wheelchairs. The registered manager commented that even those people who were quite poorly were helped to sit outside if they wished, during fine weather.

Good

Is the service caring?

Our findings

People who used the service and their relatives were very complimentary about the staff. One person said '' they are so friendly, they've got time for everyone'' and another person said ''nothing is too much bother for them''. One of the many 'thank you' cards we saw said '' we will never be able to thank you enough for all the love, care and support you have given to (the relative)''.

We saw that people in the home looked cared for: their clothes and appearance were clean. On one of our inspection days the hairdresser was attending to people and one relative commented, "they always pamper (the relative)''.Those people who were nursed in bed looked comfortable and relaxed. Some of the people who used the service were unable to communicate their needs or respond to staff. One relative told us that even when this was the case the carers always spoke to them and explained what they were doing. There was a calm and happy atmosphere in the home and staff showed compassion and kindness to people. One member of staff described how she had hung pictures on the wall near the bed of a person who was very poorly; so that when they woke they could see and touch images that were familiar to them.

We were unable to observe staff caring for people in the community, but comments we received about the service included that staff were ''very kind'' and ''very helpful''.

We observed staff interactions with people in the home and saw that staff were patient and that people were listened to. One relative commented ''they've always got their arms around someone''. We saw that staff respected people's individual diversity by allowing them freedom to behave in a manner suitable to them. One person spent long periods walking up and down the hallway: he did this freely without being told by staff to sit down, or act differently. Staff spoke kindly and politely to people and treated them with dignity and respect. One person commented that even closest relatives were not allowed in rooms when staff were carrying out personal care.

Although we did not see any information about advocacy services on display in the home, the registered manager informed us that they had the name and contact details of a service that could be used if required. Advocacy services support people to express their views, access information and help people to make important decisions about their lives.

People were free to visit the home at any time and we observed friendly interaction between visitors and staff.

The service specialised in end of life care, and had completed the 'Six Steps to Success – Northwest end of life care programme for care homes', which helps to guide in supporting people approaching the end of their lives. Information about the programme was on display in the hall, along with a 'Book of Remembrance' and leaflets produced by the charity Marie Curie, such as 'Living with a terminal illness and looking for support' which offered useful advise to people at this difficult time. The registered manager explained how she involved a person at the end of their life in 'advance care planning', so that their choices and wishes could be carefully planned. Each person was allocated a key worker, who reviewed their needs

on a monthly basis, and was involved with their care until the person died. One member of staff we spoke to described this aspect of her role as being ''the most rewarding thing I've ever done''. We saw 'thank you' cards praising staff for their end of life care. One card said ''without your care and attention (the person) would not have had such a comfortable and peaceful final few months'' and another said ''her final days were as calm and loving as she could have possibly wished for''. There was an area available for relatives to stay at the home, if they wished, when their relative was approaching end of life.

Good

Is the service responsive?

Our findings

Prior to moving into the home, a pre-admission assessment was carried out by one of the RGNs. This assessment usually took place at the person's home, or if the person was in hospital they were assessed there. The assessment enabled people to make an informed choice as to whether or not the service could meet their needs. People were encouraged to visit the home prior to admission, if they were able. One relative said ''I was shown round by a person who really knew what they were talking about''. A similar assessment was carried out on those people requiring domiciliary care, to ensure that the service could meet their needs.

We reviewed the care records of three people living at the home and the two people receiving support in the community and saw that they were 'person-centred' and contained descriptions of each individual person's care needs and how they should be managed by staff. Documentation included a nursing assessment, 'my routine' information, risk assessments such as nutrition, mobility, continence and skin integrity, and other completed charts, such as MUST, Waterlow score and weight. The Waterlow score gives an estimated risk for the development of a pressure sore and is used as part of a prevention strategy. The registered manager commented that during the last year no one had developed a pressure sore while living at the home, despite several people being permanently cared for in bed. We saw how 'my routine' information had been used by staff to personalise care. Prior to their admission to the service, one person had liked to watch television during the night, and staff encouraged this activity to continue following their admission, in order that they might feel at home.

Care plans for people living at the home were detailed and personal. For example, one care plan said ''show (the person) their clothes to see if they want to choose what to wear''. We saw that care plans were reviewed monthly by the RGNs and that families were involved in the review process if they wished. One relative commented ''they always approach me if they want to change anything; I'm kept up-to-date with everything'' and another relative said '' they have accommodated (the person's) needs.

In 2012 the home implemented a system where they checked and documented the needs of people who used the service at least once every two hours. The system, which they named ''Meaningful Moments'', had been adapted from a similar one used in a hospital environment and staff working at the home at that time were involved with its development. They used the acronym 'CHARM' to describe the 'meaningful moments'. This stood for 'Communicate – smile, Health check, Aim to satisfy any needs, Risk – is the service user at any risk, and Meaningful – ensure the visit is meaningful to the service user'. People we spoke with were positive about this approach, as it ensured that no one was left without support for long periods and it encouraged positive interaction between staff and people who used the service. In addition it helped to prevent the social isolation of people who used the service.

We saw 'handover' meetings between the RGNs were held at the start of each change of shift and details, such as changes to medication or health, about all those who lived at the home were discussed. This helped ensure that any alterations in a person's health or care needs were properly communicated. The information was then shared with the care staff so that any changes could be implemented.

A calendar of activities was displayed in the hall, but staff informed us that it was not always adhered to. Various board games were available, and one person enjoyed playing skittles in the corridor. Another person had their own computer. Several of the people who used the service were too poorly to take part in any organised activity but staff spent time sitting talking to them. One relative said ''there are frequently care staff in the lounge talking to residents'' and one carer told us that she often sat talking with people who used the service while she took her break.

People who wanted to continue practising their faith were visited monthly by a local priest who shared communion with them in their rooms. Religious services were held in the home by the priest at Christmas and Easter.

The service had a complaints policy and procedure and people who used the service and their families were given information about the process they needed to follow to lodge a complaint, when they were admitted to the service. Complaints were responded to within 72 hours and stored on file, along with details of the actions taken and steps taken to prevent a reoccurrence.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post, who was also the owner of the home. The manager was registered with the Care Quality Commission (CQC) in 2011.

The management team for the service consisted of the registered manager, an audit manager and a deputy manager. Neither the audit manager nor the deputy manager were involved in any 'hands-on' caring, as their roles were primarily concerned with the day to day running of the home, recruitment, quality assurance checks and management of the domiciliary visits. The registered manager, who was an RGN, had owned and run the home for over thirty years and was very committed to the service. People we spoke with commented on her open and honest attitude and felt that they could approach her if they had any concerns about the care provided at the home. Comments people made included '' the management is approachable'', '' I always get answers if I ask'' and ''I go straight to (the manager)''. A relative of one of the people receiving support in their own home commented about the management team '' I can ring up anytime and they are very helpful''.

People who used the service were given a variety of information about the home and the domiciliary care agency, including its vision and values, details of its facilities and staff and its organisational structure. A board containing photographs of all the staff was displayed in the home and this enabled relatives to familiarise themselves with the care and management team.

The service produced an annual newsletter to inform people of events and staff changes. This was sent to the relatives of all the people who used the service and was displayed in the home.

People living at the home, those being supported by the domiciliary care agency and relatives were provided with an opportunity to comment on the service through an annual survey. People were asked to agree or disagree with statements, which included ''I am included in discussions regarding my relatives care'' and ''my relatives/friends privacy dignity and respect are observed at Park Hills''. We saw feedback from the 2015 survey was very positive and included the following comments '' excellent care at all times and a nice homely atmosphere'', ''she is treated with compassion and is kept extremely clean and we are fully satisfied with the level of care she is receiving'' and ''would recommend the home to anybody''. Results from the survey had been displayed in the entrance porch.

We observed a happy atmosphere in the home and staff made positive comments about their work environment. One carer said '' everyone gets on'' and another person commented '' we help each other out: we work as a team''.

We saw evidence that staff meetings were held twice a year and these covered topics such as shift patterns, care needs of people who used the service and housekeeping. Staff were invited to take part in an annual staff survey and agree or disagree with statements such as '' I am provided with suitable training'' and '' I have trust in the management team''. As with the relatives' survey, the results were displayed in the home and included the following comment '' I have worked at Park Hills for many years. It's a fun, caring,

enjoyable place to work''. The registered manager had recently introduced an initiative to reward employees who 'go that extra mile', and relatives were invited to choose an 'employee of the month'.

The registered manager reviewed incidents and accidents to make sure risks to people were minimised and notifications of incidents occurring at the home and within the domiciliary care agency had been made to the CQC appropriately and in line with their registration requirements. We saw that quality assurance processes, such as audits were carried out regularly and the results acted upon. A recent 'falls' audit had identified the need for information about a person's risk of falling to be more readily available to staff and as a consequence a 'falls risk' poster was introduced.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not provided with adequate supervision.