Athena Healthcare (Park Road) Limited

Parklands Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Parklands Lodge is a purpose built care home offering nursing and personal care for up to 70 People. It is located close to Southport town centre near Hesketh Park. There were 54 people living at the home at the time of the inspection.

This was an unannounced inspection which took place on 30-31 March 2017. This was the first inspection of the service since Parklands Lodge was registered in April 2016.

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

We found some anomalies with the way some medicines were being recorded and monitored. This meant there was a risk these medicines were not being administered consistently. We found the checking and auditing systems of medicines needed improving to ensure all anomalies were being identified.

You can see what action we told the provider to take at the back of the full version of this report.

The registered manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found some supporting management systems continued to be developed and key areas such as medicines management and overarching health and safety audits needed improving.

We found the home supported people to provide effective outcomes for their health and wellbeing. We saw there was effective referral and liaison with health care professionals when needed to support people.
We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people.

We found there were sufficient staff on duty to meet people's care needs.
Staff said they were supported through induction, appraisal and the home's training programme. We identified some areas that needed further development and found that some of these had also been identified by the managers. We received reassurance after our inspection visit that some issues, such as formal supervision for staff, had now been updated.
Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken

safeguarding training in-house. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety checks were completed on a regular basis so hazards could be identified. Planned development / maintenance was assessed and planned well so that people were living in a comfortable environment.

The home was clean and we there were systems in place to manage the control of infection.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

When necessary, referrals had been made to support people on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the registered manager of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice. Meal time was seen to be a relaxed and sociable occasion.

People we spoke with said they were happy living at Parklands Lodge. Staff interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people. People told us their privacy was respected and staff were careful to ensure people's dignity was maintained. Staff were able to explain each person's care needs on an individual basis and how they communicated these needs.

People we spoke with and their relatives felt staff had the skills and approach needed to ensure people were receiving the right care.

People felt involved in their care and there was evidence in the care files to show how people had been included in key decisions.

Social activities were organised in the home. People told us they could take part in a variety of social events which were held.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw there were records of complaints made and the manager had provided a response to these.

The registered manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always administered safely. Medication administration records [MARs] were maintained but some recording of medicines were not clear or consistent.

Staff had been been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

There were enough staff on duty at all times to help ensure people's care needs were consistently met.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards were routinely monitored.

The home was clean and we there were systems in place to manage the control of infection.

Is the service effective?

Good

The service was effective.

We found staff were supported through induction, appraisal and the home's training programme.

We found the service supported people to provide effective outcomes for their health and wellbeing.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.
We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff told us they had time to spend with people and engage with them.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Good

The service was responsive.

Care plans were being reviewed and monitoring of people's care had improved which evidenced a more individual approach to care.

There were social activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager and senior managers for the provider were able to evidence a range of quality assurance processes and audits carried out at the home. We found some supporting management systems continued to be developed and key areas such as medicines management needed improving.

There was a registered manager in post who provided an effective lead for the home and who had developed a positive culture of care in the home.

Parklands Lodge

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection. The inspection team consisted of an adult social care inspector 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.

Prior to the inspection we collated information we had about the service and contacted the social service contracting team to get their opinions. We also reviewed other information we held about the service.

During the visit we were able to meet and speak with 11 of the people who were staying at the home. We spoke with six visiting family members. Some of the people living at the home had difficultly expressing themselves verbally. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 14 of the staff working at Parklands Lodge including care/support staff and senior managers.

We looked at the care records for five of the people staying at the home including medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed at the service. We found some anomalies with the recording of some medicines which meant it was not clear if the medicines had been given as prescribed.

We reviewed medicine administration on the nursing unit; we were told that systems on each unit were the same. We looked at eight medication administration [MAR] records for people. We saw one person's MAR chart had not recorded their regular prescribed dose of paracetamol medicine. It was not therefore clear whether the medicine had been administered. We were told that a second supportive chart documented all paracetamol administered with the times and dose given. This was important as the administration of paracetamol, to be given safely, should not be given less at less than four hourly intervals. We found this record had also not been completed fully; on some days the paracetamol was not recorded at all and on other days once or twice. We found this the same for one other person who was prescribed regular paracetamol.

We checked how external preparations [creams] were administered. We found creams for two people had been supplied. We were told these were administered daily by care staff. Neither of these creams were recorded on MAR records. We were told by the nurse that there had been an issue with a recent delivery from the pharmacy which meant some MAR charts had not been sent with medicines and staff had therefore had to complete handwritten records. We asked whether the creams had been applied. The nurse checked with care staff who said they had applied creams that morning. We were shown records for care staff to sign once they had applied the cream but these had not been completed. One had last been completed four days prior to our inspection and another had not been completed for two days. Both charts were completed irregularly.

We discussed the lack of accurate records with the manager and deputy manager. We asked what auditing mechanisms were in place to check if medication was being administered safely. We were shown an audit tool which checked an example of one person's MAR charts weekly. This meant four people were audited over a month [out of 54 currently in the home]. We questioned the effectiveness of this as the anomalies we saw had not been identified. There was no other audit tool in use, although both managers reported the need to develop a more in-depth auditing system.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people in all areas of the home and asked if they received their medicines on time and could request tablets, such as painkillers, should they have a headache. One person said, "They're always on time – I get my tablets each day." Another person told us, "They [medicines] are brought round twice a day at least. They [staff] keep a hold of the plastic phial and wait until you take them" and "I take one tablet every morning. I keep them in a drawer in my room."

A medication policy was in place. Staff who administered medicines had received medicine training and had

undergone a thorough competency assessment to ensure they had the skills and knowledge to administer medicines safely to people.

We found medicines to be stored safely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the medicines' fridge was recorded daily. This helped to ensure the medicines stored in this fridge were safe to use.

Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We saw controlled drugs were stored appropriately and records showed they were checked and administered by two staff members. We checked a number of medicines, including a controlled medicine and found the stock balances to be correct. There was only one control drug being administered on the nursing unit. This was for pain relief and was administered every three days by the application of a patch to the skin so the medication could be absorbed over this period. We made a good practice recommendation for the daily monitoring [recording] of this patch to ensure it remained in situ.

People had a plan of care which set out their support needs for their medicines, including 'as required' (PRN) medicines. We checked three people who were on PRN medication. Two of these had a supporting care plan [PRN care plan] in place. The third was put in place at the time. It was therefore clear why the person was on the medication PRN and in what circumstances the medication could be given; this helped ensure consistency of administration.

We saw four people were prescribed thickening agents added to drinks. Thickening agents are added to drinks when a person has been assessed as having difficulty swallowing. We found staff we spoke with were knowledgeable regarding the administration of these and we saw, over a meal time, that people were receiving the right consistency of thickening agent.

We spoke with five people about whether they felt safe living at Parklands Lodge. All five people said they felt safe and were not afraid of anything or anyone. Most were able to describe a number of aspects of Parklands Lodge that contributed to this, including the general environment, security measures and staff. Two people living in 'Bluebell' unit [for people living with dementia] showed us they had keys to their rooms, which meant they could leave their rooms locked and come and go to them as they wished, feeling secure that nobody could enter while they were somewhere else. We also observed several examples of staff members successfully intervening to reassure or comfort people on Bluebell who were showing initial signs of fear or distress; this included catering and domestic staff, not just designated carers. One person told us, "The environment itself [keeps me safe]; it's made safe by the manager, really; he's the one in control." Another person commented, "Oh yes – the whole atmosphere, the people, everything. You feel completely safe here. I was not safe at home and now I am."

We found arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. The maintenance person showed us comprehensive records of all of the routine environmental checks made in the home. Following the inspection we were sent information to evidence an overall health and safety audit had been carried out in September / October 2016 and this had been repeated following our inspection. The manager advised that a new development would be the introduction of a regular health and safety meeting involving key managers as well as the maintenance person. We saw the general environment was safe.

A 'fire risk assessment' had been carried out and updated at intervals. We saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation in case of an emergency. The home was new and had only been registered for a year. All maintenance / safety certificates were therefore up to date we saw that the maintenance person was aware of when these needed updating; for example portable appliance testing [PAT] was due soon. Overall there was good attention to ensuring safety in the home and on-going maintenance.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at three staff files of staff recently employed and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been made and staff records were clear and it was easy to access information. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

When we visited the home we checked to see if there was sufficient staff to carry out care in a timely and effective manner. During the visit we made observations in the day area/lounge and spoke with people who were living at the home. We saw that people received care on time and were not left for long periods. People told us there were enough staff to support them. People commented, "Yes, it's well-staffed, therefore normally things run smoothly. If something happens, for example if someone collapses, they soon get things back to normal", "Oh yes; sometimes much more staff than you can see here today", "There's the odd time [when staff numbers are lower] when someone's away, but that's very rare. I think basically it's well-staffed."

People living at Parklands Lodge told us that calls for assistance were always answered promptly or within a reasonable time period and nobody had any complaint to make about this; "Immediately. If you press the 'bed bell' it's an instant response", "I press for a cup of tea in the morning, and they come" and "They're here in a couple of ticks."

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was stable. One staff told us, "It's the best home I've worked in – there's always plenty of staff."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available. The registered manager had reported through a number of instances to the local authority safeguarding team and had assisted with investigations and had also responded positively to any recommendations made.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails.

When we looked round the home we found it to be clean. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. We looked at the care of one person who had special nursing measures in place to ensure any risk of spread of infection was minimised. The care plans were clear and showed there had been good liaison with external infection control professionals.

All of the people living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state. Several people commented that their rooms were cleaned every day and all said they were confident that staff followed hygienic practices.

Every shared space we observed, and all bedrooms visited, were very clean, with no offensive odours anywhere. All bathrooms and WCs were fully resourced with soap and paper towels/dryers; and there were hand sanitisers on all corridors. Staff wore disposable aprons and gloves both when providing personal care and when supporting people with food and drinks. Comments from people included; "Definitely [clean]; they never stop cleaning, and if someone's not well the staff make sure they stay in their room until they get the all clear, so things don't get spread around" and "The domestic staff - they're always cleaning!"

Good

Is the service effective?

Our findings

During our inspection we reviewed the care of five people living at the home. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. One person we reviewed had experienced changing care needs over a short space of time and these changes had been monitored by staff in liaison with the person's GP and other health professionals. When we visited the person was being assessed for end of life care. We spoke with visitors who told us their relative was being well cared for and staff were very professional and supportive. They told us, "Staff are very good at keeping us up to date and the care has also been very good."

Another person was being carefully monitored because of an infection they had acquired. There were safe nursing practices to minimise any risk of further infection and there had been regular liaison with heath care professionals regarding treatment.

When we looked at people's care notes we saw references to referrals and support for people from a range of health care professionals. People we spoke with told us, "The staff know when I am poorly", "You're straight to bed [if ill], they make sure you're okay and have everything you need, and get the GP", "I've never needed it [to see a doctor] but I know they would call one if I did", "They will bring a doctor in, yes; they did it for [person] when s/he was very poorly" and "If they [staff] say the GP needs to come out, they come out quickly."

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care.

We looked at the training and support in place for staff. There was training coordinator who currently had one day a week input at Parklands Lodge and a further day at a sister home for the provider. They told us they were involved in delivery of some training sessions and also developing overall policy for the provider. In addition to the induction sessions the training coordinator covered sessions on person centred dementia care, the Mental Capacity Act, safeguarding [of vulnerable adults] and infection control.

The training coordinator advised us that one of the senior carers has a BSc in Dementia Studies from Bradford University and was the 'Dementia Champion' at Parklands. There was a focus on the importance of documenting people's life story as this was essential to person centred care for people living with dementia.

The training coordinator supplied a copy of a staff training matrix and records for training undertaken and planned. This reflected a series of 'mandatory' training sessions for staff. We saw training had been carried out in subjects such as health and safety, safeguarding, infection control, fire awareness, first aid, moving and handling, dementia care and the Mental Capacity Act 2005.

We saw that much of this training was online computer based training. Staff told us that some of this had been difficult to access and therefore they had not completed it [we fed this back to the registered manager for consideration].

The quality of the induction training was not clear. Some staff reported they had received a good induction and others felt this could have been better. Both the register manager and training coordinator explained the developing standards around training and this was ongoing. We were sent a report for a 'quality meeting' dated February 2017 which gave an overview of current training developed and how this was to be developed further in the future. The report outlined a good ethos of training provision for staff which evidenced how it supported 'The ethos of the Athena Health Care Group (AHCG) to provide high quality person-centred care to residents and their families'. The training coordinator was aware of the 'Care Certificate' which is the government's expected standard for induction for all care workers. There were seven care staff undergoing this course, linked to their induction.

The registered manager told us that some staff had a qualification in care, for example, QCF (Qualifications Credit Framework) and this was confirmed by records we saw. We saw the percentage of staff with these qualifications was 75% on this inspection. We met a visiting QCF assessor who was supporting seven staff currently on programmes. We were told, "There are good standards, particularly regarding dementia care. There is a good ethos of training in the home. Staff are very reflective and calm and this has an effect on the residents [living with dementia]."

Overall, staff we spoke with said they felt supported by the registered manager and the training provided. The 'Draft learning and development strategy' we were shown stated the importance of; 'Supervision and reflective practice; In aspiring to become a learning organisation, staff and managers at all levels should embrace and value the concept of learning from experiences as part of their work'. We spoke with four staff who told us that, although they felt supported overall, they had not received any formal supervision with respect to supporting them in their role. The deputy manager explained some supervisions had been completed and showed us records for these – they amounted to only a quarter of the current staff and did not meet the providers own target of one formal supervision session every six months.

The register manager sent us an update following the inspection visit; 'The management team of myself, deputy, third in charge and the nurse team have completed formal supervisions with all employees over the past week. These have formally documented issues for development and any areas of training and further support required'.

We asked about staff meetings and we were told that these were held. Staff we spoke us told us the managers of the home were constantly asking for their opinion and input. They had also completed a staff survey so their views could be heard. Staff felt the manager did their best to act on feedback they gave.

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had applied for a number of people to be supported on a Deprivation of Liberty Safeguards (DoLS) authorisation. The applications were being monitored by the registered manager of the home. We saw that if people were on a DoLS authorisation there was a supporting care plan to reference this.

The staff and registered manager were able to discuss examples where people had been supported and

included to make key decisions regarding their care. In one example two people, with varying levels of mental capacity to consent, were being supported in their wish to engage in a close relationship. We saw supporting assessments and documentation which supported good practice in this area and made use of mental capacity assessments for each person with good supporting care plans and liaison with, in one person's case, the local advocacy service.

Other examples included care files showing were people had consented to their plan of care. We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members]. One person was unable to consent to their care and had a relative who had been appointed as Lasting Power of Attorney (LPA) to act in their best interest; this was clearly documented with evidence of the LPA forms on file. We spoke with the relative who told us that staff were keen to make sure the person's legal rights were clear.

We asked people what they thought of the food at Parklands Lodge, and whether there was enough. We observed lunch in one of the dining rooms. This room was bright and welcoming, with attractive tables and chairs. Tables were set simply with knives and forks; there were flowers on every table. People were served and supported by ample numbers of staff: as well as catering staff we saw five members of the care staff available to give support or actively supporting people, two of whom were supported one to one. Two people chose to eat independently in the shared lounge and were provided with appropriate tables to eat from.

The dining room was quiet and calm throughout the meal, and interactions between people were positive. Staff supporting people to eat maintained quiet conversation with the people they were supporting, and offered support/food courteously and kindly.

The meal offered was soup and a choice of sandwiches, followed by a wide selection of puddings. The soup was homemade and both smelled and looked appetising. Both cold and hot drinks were offered. Comments by people included; "The food's always good", "The soup's usually very good", "If you said 'Gee I could fancy a trifle, you'd come in at teatime and there'd be a trifle there for you."

People said there was plenty of food, including snacks at different times of the day. Relatives commented on the efforts made by staff to keep their loved one eating and drinking. One commented, "The staff have tried desperately to keep [person] hydrated; excellent care." We were told by the deputy manager that family members could choose to have meals with their relatives, by prior arrangement.

We asked if people were shown/given a menu and if they could ask for variations from this if they wished. All of the people we spoke with confirmed that they were given choices from a menu every day, for the following day's light lunch and main evening meal. Everyone that we spoke with said that they could always ask for something different if they didn't like the choices offered, and were confident that they would be given something they liked.

Parklands Lodge was adapted to meet the needs of people living with dementia. We were told that there were still some adaptations to be made to 'Bluebell', to better meet the needs of people living with dementia. We noted that the doors to WCs had been repainted in yellow, to make them easily identifiable, and had clear picture and word signage, thus promoting people's orientation, confidence and independence.

Good

Is the service caring?

Our findings

People living at Parklands Lodge and their relatives told us they felt they and others were treated with respect and kindness. Throughout the inspection we saw staff speaking kindly and politely to people, and relationships were evidently very friendly and mutually respectfully.

Where people were being given support, staff were unfailingly gentle and respectful of people's physical and emotional well-being. For example, a person being transferred from wheelchair to lounge chair was supported by two staff members, who showed skill and knowledge in their use of the equipment. They additionally ensured the person felt both safe and comfortable, talking to them throughout and explaining what was happening next and checking that they were settled once seated. The person concerned appeared completely at ease throughout.

We also observed a visitor being invited to reassure their family member before personal care was given, to lessen any potential distress. When we asked a staff member what would have happened if the visitor had not been available, they replied, "We would have to have gone ahead anyway [with care needed] but we don't like to see them [people] get upset so we do anything we can to avoid that.'"

People told us, "I only really need help with showers, and they are very good with that, yes", "Oh yes, staff are very, very kind here", "Yes, they're very kind and they'll do anything for you" and "Care here has been very good. All the staff are caring; I think they like working here."

People told us staff did sit and spend time chatting although most people commented that staff were busy and worked hard. We saw several instances of various staff members taking the time to talk individually to people or generally as part of a group. These included a part-time staff member speaking one-to-one with a person to ascertain their interests and views about their care; a member of the activities team talking to several people about their impressions of the different teas they had been served as part of a 'sensory' experience, and sharing personal memories/reminiscences.

We spoke to a member of the maintenance team whom we saw talking one-to-one with people about tasks being undertaken in their rooms in a friendly and patient manner. This staff member told us they enjoyed this interaction with people at the home, fitting it in whenever there was 'down time' between tasks.

People told us they were listened to and staff acted on their views and opinions. One person commented, "You could say that, yes. What I like is lots of showers and I do get those, more or less when I want - within reason, of course." Other people and their relatives commented, "I would imagine so. Oh yes, I can get up whenever I like [when prompted further] and go to bed as early or late as I like" and "We can now email any concerns or observations [about loved one's care] and they're addressed no problem. It's nice to know that facility's there."

One person had their own areas where they liked to sit and staff knew where they liked to sit in the lounge. They said, "Wishes are respected – the staff are always very, very good about that."

Visitors said the home was very relaxed and they could visit at any time. One commented, "We're here every couple of days, for as long as we like. They [staff] look after us, too – drinks are offered. And they will ring any time of night or day and let you know how things are and you can come in if you want to."

We saw that people's dignity and privacy was respected. People living at Parklands Lodge and their relatives were very positive and described staff knocking before entering rooms and closing curtains/doors when giving personal care and support. We were told that glass panels at the ends of each corridor had been replaced with opaque, decorated glass, to enable people to feel private when using corridors to rooms. When observing in one lounge, we saw that when moving a person using a hoist, staff took care to cover the person's legs, which would otherwise have been exposed; using a blanket that they had ensured was to hand.

Comments included, "Privacy is not breached in any way. They use common decency, of course: close doors and curtains", "I'm very happy with that [privacy]; they're very good" and "I like the fact that we have our own bathroom and toilet."

Care plans we viewed contained evidence of people and /or their families being involved in the care planning process. This was evident through signed consent forms and records of discussion with people and families.

End of life care had been discussed with people living at the home to enable staff to provide care and support in accordance with people's wishes and needs. The registered manager and training coordinator informed us that formal end of life training was going to be arranged for staff to support their learning.

Good

Is the service responsive?

Our findings

We asked people how staff knew what they liked/disliked, or about their interests, and if they could choose what they wanted to do, such as activities, life choices, people they want to be with. One person said, "They ask you and everybody seems happy enough." Another commented, "I don't really know; they do ask now and again. You can choose the things you like, just as if you were at home but you've got people to talk to; you're not on your own. I have a friend who lives [in the room] next door."

We saw a good example of how a close friendship between two people living in the home had been supported with involvement from other key people concerned.

We asked people about their involvement with their plan of care. People said the staff had discussed their care and support with them. Relatives we spoke with confirmed that staff communicate well and included them in the care planning. One said, "We have had care plan involvement, two reviews, and there's constant contact to let you know or ask what you think about the care."

People told us they were able to make choices. They said they could choose how and where they wished to spend their day, what meals they would like served and what time to get up and retire at night. A number of people chose to spend time in the lounge whilst others preferred to spend time in their own room.

We looked at eight care records for people. Care records held an assessment of people's needs; this ensured the service was aware of people's needs and that they could be met effectively from admission. There were also specific assessments of areas such as, nutrition and mobility. People had a plan of care. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care.

Care plans were specific to the individual and there was reference to people's life history to get to know people's social care needs in more detail. These records, along with staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs.

We saw staff supporting people in accordance with their needs and wishes during the inspection. Staff also responded promptly when people required assistance so as not to leave people waiting. Staff discussed with us how they encouraged people to be independent with the use of walking aids where appropriate, though were 'on hand' to provide support when needed.

We were told that the home had two activities coordinators and a recently appointed lead coordinator. We spoke with two of the activity staff while they were providing activities for people. They told us that there was a range of activities planned for each week, reviewed regularly with the input of people living at Parklands Lodge, which was gathered as part of both group and individual discussions.

A well-presented timetable was prominently on display throughout the home, including in lifts. This was alongside other interesting, relevant and up-to-date information similarly on display, for the benefit of everyone. There was a glass-fronted cupboard in the downstairs 'activities' lounge filled with a wide range of interesting 'vintage' items, relevant to both men and women and I was told these were used routinely to start a conversation with a person or persons.

Activities staff said that people could opt in or out of activities as they chose and they tried to ensure that activities suited all needs and wishes over time. On occasions a member of the team might decide on behalf of a person, unable to make an informed choice but, if possible, in agreement with family members, if they felt the person would particularly benefit from an outing for example. The lead activities staff also described the home's active involvement in a newly-launched regional 'hub' approach to activities that invites and includes members of the wider community, for mutual benefit.

We observed people involved in activities in the ground floor lounge and also on the first floor unit for people living with dementia. A 'sensory' activity involved tasting a range of teas, with the help of a person living at the home. Everyone present was involved to a degree that suited their choice, and the leader worked hard to include everyone in discussion, vocabulary enrichment and personal reminiscence.

People responded very positively to questions about activities; "On nice days, we can go for a walk to the park – about 8 to 10 of us – and get a coffee. They're extremely good on trips. The hub's a good idea; you get more people together then. I do what I can to help. [This person was also an active participant in activities development]; "Oh yes, they are very good in that respect", "Basically yes, there's plenty going on; I'm looking forward to going into the garden in summer" we visited the garden and found one person involved with a staff member in a gardening project.

People had access to a complaints procedure and this was available to people within the home. People we spoke with told us they knew how to raise concerns and relatives agreed. A system was in place to record and monitor complaints and those we viewed had been responded to appropriately in line with the provider's policy.

Everybody we asked was aware of and happy with consultation and complaints processes; "We do have meetings in case there are any complaints, usually supervised by the manager. I've never had reason to make a complaint", "There are meetings, and they do listen to you", "There are meetings – maybe two in the last six months – and I think they listen. I don't really think I could find a complaint" and "I think we might have meetings but you just need to ask one of them and they see to it [if any concerns/complaints]."

Feedback was also sought through the use of quality assurance surveys. We saw notes from residents' and relatives meeting held in January 2017 which had been well attended. This enabled people to have a say in how the home was being run.

Requires Improvement

Is the service well-led?

Our findings

As part of the feedback to the registered manager and senior managers we identified some key areas of the homes management where improvements were needed. Most notably the auditing processes regarding medication management. Existing audits were not fully developed and had not identified the issues we found in administration of medicines. Similarly, standards around training and supervision of staff, although currently sufficient for most staff, were still, at the time of our inspection visit, not consistent for all staff [first identified on management audits from November 2016]. The management team have, since our feedback been responsive and acted on these identified areas of concern.

We found a strong ethos of care in the home. This was provided by the leadership of the registered manager who evidenced good clinical skills and a solid knowledge base; particularly regarding dementia care. Staff, people living at Parklands Lodge and visitors all spoke positively about the registered manager who was described as supportive, open and a consistent presence in all areas of the home. The registered manager told us, "It has been an intense ten months [since the home had its first admission] and I am pleased with the team's performance and the ethos of Parklands Lodge. It is a care environment that focuses on the care delivery experience." We found the registered manager and the other senior managers to be open to feedback and positive in their responses; there was a realisation that much progress had been made but some areas still needed further development.

The overall approach by the registered manager was exemplified by some interview comments from people living at the home and their relatives who said, "[Referring to the manager] you can tell when a person is trying to make things as easy for everyone as they can", "I really admire [manager]; I've reflected on his ability to respond and change according to need. For example communication was a bit of a problem at first but it's been sorted and I'm more than happy", "The low staff turnover here tells you something. And new staff seem to fit in really well. [Registered Manager] has been very good; they've done their very best here – it's a lovely place."

There was a management structure for the service from the Chief Executive Officer for the provider to the Head of Care; Commissioning Manager, Registered Manager and Deputy Manager. There was also a training officer for the provider. We were told there were final adjustments to be made to this structure which would be formalised by May 2017.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety [required further improvement], care planning and routine checks for health and safety regarding the environment. Senior managers had also conducted some audits including a 'compliance audit' on 30 November 2016 which covered clinical care, Mental Capacity Act 2005, personal care and training; induction training for staff had been identified at that time as needed improving. In addition the Head of Care had carried out a full health and safety audit of the home over a period from May – November 2016.

We also saw that accidents and incidents, although low in number, were recorded in good detail and

analysed for any patterns or trends so that any lessons could be learnt.

The service was particularly strong at collecting feedback from people living at the home and their relatives as well as staff. We saw a series of surveys and meetings aimed at seeking feedback about the home. From the staff surveys, areas identified for improvement / development included induction training, team building and some areas for on-going training development. The action plan was being addressed by the training officer. People who live at the home identified some areas for improvements such as activities and these had been addressed.

These systems had helped the registered manager to focus on some immediate issues for improvement. The registered manager was aware that an overall quality assurance framework still needed to be developed including an index of audits, who was responsible for carrying them out and their frequency.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always administered safely. Medication administration records [MARs] were maintained but some recording of medicines were not clear or consistent.