Runwood Homes Limited

Park View

Inspection report

Priory Road
Warwick
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Date of inspection visit: 14 & 15 October 2015
Date of publication: 26/11/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 14 & 15 October 2015 and was unannounced.

Park View is a purpose built residential home which provides care to older people including people who are living with dementia. Park View is registered to provide care for 63 people. At the time of our inspection there were 60 people living at the home.

A registered manager was 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 and associated Regulations about how the service is run.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at Park View and relatives we spoke with agreed their family members were safe. However, people, relatives and staff told us they felt at times there were not enough staff to meet their needs. During the inspection we found the staffing

Summary of findings

arrangements were not always sufficient to enable staff to manage risks and meet people's needs safely. There were instances where staff were not available to meet people's needs.

Some care plans were not sufficiently detailed to support staff in delivering care in accordance with people's preferences. There were occasions when delivery of care did not support people's needs. For example, we saw instances where people were potentially put at risk because risks to their health and safety were either not identified, or were identified but not managed properly.

Staff received training in areas considered essential to meet people's needs safely and consistently. The registered manager told us they had identified staff required further training in specific areas to make sure they supported people when their needs changed.

People told us staff were respectful and kind towards them and relatives confirmed this. When staff provided support to people, they were caring and kind. Staff protected people's privacy and dignity when they provided care and asked people for their consent before care was given.

Staff understood they needed to respect people's choices and decisions. Assessments had been made and reviewed to determine people's capacity to make certain decisions. Where people did not have capacity, specific decisions were taken in 'their best interest'. Relatives told us they were kept informed when certain care decisions were required and that their views were taken into account.

The provider was meeting the requirements set out in the Deprivation of Liberty Safeguards (DoLS). At the time of this inspection, one application had been made under DoLS for people's freedoms and liberties to be restricted.

The registered manager had contacted the local authority and was in the process of reviewing people's support to ensure people's freedom was not unnecessarily restricted.

Family and friends were able to visit when they wished and staff encouraged relatives to maintain a role in providing care to their family members.

Some people we spoke with told us they were supported to be involved in pursing their own hobbies and interests. Activities were available and provided to people living in the home, however it was recognised further improvements were required so staff were able to spend more time with people. The staff member responsible for providing activities was enthusiastic and spent time engaged with people in how they wanted to spend their time.

People were supported to maintain their health and were referred to health professionals where appropriate.

People said they were offered a choice of meals however on the day of our visit there was only one choice offered. During our inspection we saw people who were identified at risk of dehydration and malnutrition were not supported or encouraged by staff to maintain their general health and wellbeing.

Regular checks were completed to identify and improve the quality of service people received, although some checks had not identified some of our concerns regarding people's care and associated risk records. The registered manager's quality checks fed into an overall action plan to ensure improvements were made in the quality of service people received.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People told us they felt safe and staff understood their responsibility to report any observed or suspected abuse. Staff told us they were busy at certain times of the day and night so there were some delays in meeting people's needs. People's risks had been assessed, but plans and guidelines advising staff how to manage these safely were not always up to date and followed. People received their medicines when prescribed from staff who were suitably trained and competent to administer their medicines.

Requires improvement

Is the service effective?
The service was not consistently effective.

People and relatives were involved in making decisions about their care. People received support from staff who were competent and trained to meet their needs. Where people did not have capacity to make decisions, support was sought from family members and healthcare professionals in line with legal requirements and safeguards. People were offered meals and drinks that met their dietary needs, but some people did not always receive support and encouragement to maintain their health and wellbeing.

Requires improvement

Is the service caring?
The service was not consistently caring.

Staff provided care in a kind and sensitive manner however there were periods of time when people had limited interactions with staff, or staff were not available to support people due to time pressures. People told us when staff spent time with them, staff were patient and understanding.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People's care records were reviewed but they did not always reflect the levels of care and support people required which meant staff were not always responsive to meet people's needs. The registered manager responded to people's informal concerns and written complaints which had been resolved to people's satisfaction.

Requires improvement

Is the service well-led?
The service was not consistently well led.

Requires improvement

Summary of findings

People were complimentary and supportive of the registered manager but staff felt some of their concerns were not listened to. There were processes that checked the quality of service, such as regular checks, meetings, surveys and quality audits that identified improvements and in some cases, improvements were not always made.

Park View

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 October 2015 and was unannounced. We returned on 15 October 2015 which was announced so we could speak with as many people as possible. One inspector carried out the inspection on both days.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We also looked at the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. During the inspection we found an example where the provider had not submitted a specific statutory notification to us relating to an approved DoLS application. We also spoke with the local authority but they did not share any information with us that we were not already aware of.

We spent time observing care in the lounge and communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with five people who lived at Park View, five visiting relatives and two visiting health care professionals. We spoke with three care team leaders, five care staff and an activity co-ordinator (in the report we refer to these as staff). We spoke with the deputy director of care services, a dementia services manager, a regional care director, the registered manager and assistant manager. We looked at four people's care records and other documentation related to people's care including quality assurance checks, management of medicines, complaints and incident and accident records.

Requires improvement

Is the service safe?

Our findings

We asked people if they felt there were enough staff to keep them safe and to meet their individual needs. People we spoke with had mixed views about staffing at the home and whether it supported their physical and emotional wellbeing. Comments people made were, "There is enough and they are friendly", "I have asked for help, they do nothing" and "They (staff) are very busy, you expect to wait." To explore these concerns further we spoke with visiting relatives to get their views about the support staff provided and whether the staff support met their family members needs.

Three visiting relatives expressed their concerns to us that staffing levels did not always provide the care they wanted for their family member. One relative said, "We wanted [person] here because of their dementia. The staff are brilliant, but, there is not enough. It would be great for staff to spend time with people." Another relative told us staff provided care that was, "Task based." They said their relative had anxieties about leaving their room and staff did not engage or encourage them to do things they wanted to do. This relative said, "It's always up to [person] to say, rather than staff knowing." This relative told us staff completed lots of records, but they never saw staff read them. They said the records would have told staff what their relative's emotional and physical needs were and how to support them in a personalised way.

We observed staffing levels on both days of our visit to see if there were sufficient staff to keep people safe and to meet their support needs. There were 60 people living at the home at the time of our inspection. We asked staff about people's dependency levels and were told 14 people required two care staff members to transfer. A further seven people required support from one or two care staff, dependent upon their health condition at that specific time. There were eight members of care staff and two care team leaders who provided care and support to people across three floors. Staffing levels dropped to seven care staff and two team leaders in the afternoon and three staff and one team leader covered the night rota.

Staff said when unplanned absences occurred, they had worked on occasions below expected levels. The registered manager told us they had dropped below expected levels, "Two or three times in the last two months, particualy if absences were unexpected." They told us it was difficult to cover shifts at short notice but they were recruiting additional bank staff so more staff could be available to cover shifts. The registered manager said they ocassionally covered the floor to help out, such as mealtimes. They also said, "I covered medications recently to help care team leaders support staff."

People told us, and our observations showed, staffing levels were not sufficient to meet people's needs. For example, we observed lunchtime for 30 minutes in one of the five dining rooms. We checked to make sure people received support with eating and drinking. There were 11 people in the dining room on the first floor and for most of the time there was only one staff member to support people. This staff member then left the dining room to serve further meals in another dining room which meant there were no staff available to support people. Records showed two of the 11 people required encouragement and support with eating and drinking. One of those people refused their meal and the other only ate a small amount. When the staff member returned, this went unnoticed and both people's meals were discarded. People were not asked if they wanted anything else or how they were feeling. Staff told us they were rushed at meal times with one staff member saying, "If there are two of us, I will feed as quick as I can."

Staff we spoke with all said staffing levels were not enough to help them meet people's needs. We asked staff what impact this had on people living at Park View. One staff member we spoke with told us about one person who was prone to falling. They said, "[Person] had two falls on Saturday. They fell again on Monday, a visitor picked him up twice. We didn't see it." This had potential for people at risk, not to receive support quickly enough to keep them safe.

We asked staff if there were certain times that were more difficult than others. Some staff said mornings were a concern because they could not get people up, washed and dressed in time for breakfast. Other staff said afternoons were a concern because staffing numbers decreased by one staff member from 2.00pm which meant they had even less time to spend with people. One staff member said, "I feel we are not doing enough to meet their needs. We are not around enough to interact." This staff member told us if people asked for help it was not uncommon for them to have to wait before assistance was

provided. This staff member said, "It can be 10 or 20 minutes. There is only two of us now and if we are with someone, people have to wait. It happens most shifts. It should be recorded, but we don't."

Another staff member shared these concerns. They told us staff worked hard but said, "We struggle. There are 23 people to three staff (on one floor) and in the afternoon, we drop to two. People don't get quality time, certainly not today or yesterday." In one dining room we saw three people were eating breakfast at 11:30am. We asked staff if this was people's preferred routine. One staff member said, "No, night staff had not got people up and day staff were struggling to keep up, so it meant these people did not receive personal care until late this morning." We asked how this would affect their lunch which was served from 12:30pm and staff said they may have to delay it. We asked a staff member if this affected the time people received the medicines. The staff member said, "It's very difficult with three staff. We are high dependency. I am doing medicines this morning and it took me up to 10:45am. We are now late doing lunch medicines." We checked to make sure people whose medicines were time critical had received them on time and found staff had prioritised those people.

People said if they rang their call alarm bells staff usually came quickly although people said waiting times varied. When we talked with a person in their room, we pressed their call alarm bell to see how quickly staff responded. It was seven minutes before a staff member responded to the call bell. The person with us said, "That's not good, it's always like this. Staff pass me when I ring my bell. They say, oh, it's only [person's name]. I don't know what I have done. It's not right."

People told us staff did not always spend enough time with them, such as sitting with them and having a conversation. Some of the people we spoke with said they would like this and one person said, "They (staff) are always busy. They work very hard." We asked a staff member if they went in to see people for a 'chat'. One staff member said, "To pop in for a moment, we don't get chance. We are not doing enough to meet their needs." Other staff we spoke with echoed this.

We were concerned that staff levels and the dependency needs of the people had impacted on the levels of care and support people received. Staff did not always have the time to support people in a way they needed to help keep them safe and protected from risks.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Records showed some risks to people's health and welfare had been identified and assessed. For example, risk assessments were completed for people who were at risk of falling, limited mobility and how to manage risks for people who could develop skin damage. People's care plans described how staff should support them to meet their needs and minimise risks to their health. Staff told us they knew about some people's risks but did not always have time to refer to care plans. Staff said they were supported by care team leaders and information at handover enabled them to provide the care people required.

However, we found that not all risks to people's health and safety were being properly managed. For example, we looked at the care records for one person and found risks to their diet had been assessed by dieticians before they moved into the home. The person's records showed they should have prescribed fortified drinks to maintain a nutritious and balanced diet to reduce their risk of losing weight. We spoke with this person's relative who was visibly upset. They told us they visited their relative but had to support them to eat because they could not find staff to help. This relative also said they were concerned because their family member may have lost weight because they were not eating. Staff and records confirmed the person had not been given any fortified supplements as prescribed. Upon admission to the home, the person had not been weighed so we could not tell whether their weight had changed. Identified risks around this person's nutritional intake, had not been safely managed to maintain their health.

Whilst we were inspecting the home, a person had fallen a number of times whilst in their room. Staff told us and daily records showed this person was identified as being at risk of falling. Following these falls we observed the person in their room sitting low down in their chair. We asked staff how this person was supported following their falls to help keep them safe. One staff member told us the person had an alarm mat which informed staff when the person was in contact with the mat, and then staff attended. We went into this person's room and found the alarm mat was placed under the person's bed and not by their chair. Staff could not explain why the mat was not in the correct place,

Requires improvement

Is the service safe?

although they all knew where it should be placed so they would be alerted to provide support. Some staff told us this person needed to be observed every 30 minutes to check they were safe, however 'observation charts' showed the person had not been monitored for long periods of time. This was because some staff told us they were unaware of the correct frequency of checks which meant risks to this person's health were not being managed safely.

Staff told us how they managed the care of people who displayed behaviours that challenged so that the person, other people and staff were safe. We looked at the care records of one person who staff told us needed two or three carers when they required personal care. There was no information that recorded the person's behaviours, signs or triggers, or guidance for staff in how to manage risks safely. This meant risks to this person were not identified and managed properly. We spoke with the registered manager about this who agreed to update the care plan to ensure it reflected the support the person required.

We found risk assessments were not always reviewed and updated when people's needs had changed. For example, we looked at one person who was identified as at risk of weight loss and this person was required to be weighed weekly to monitor their weight. We saw this person was last weighed on 11 October 2015 and could not find records to show whether they had been weighed since that date. The registered manager told us this person no longer required to be weighed weekly, however the care records and staff knowledge did not support this. We looked at another care record for a person that showed they required walking sticks to mobilise when they actually used a walking frame. Not all staff knew which equipment this person needed and inconsistencies in records meant staff did not always have the correct information to support people to meet their needs and manage risks safely.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

People told us they felt safe living at Park View and people told us they got on well with other people and staff in the home. People gave us examples of what made them feel safe, such as, "Staff check on me at night which makes me feel safe" and "I can lock my door, I leave my handbag here so I know it is safe."

Staff understood what to look out for and what action to take if they suspected people were at risk of harm or abuse. Comments staff made were, "I would tell social services and the police" and "I would report it [registered manager] straight away and check people are okay." Staff told us they had not been made aware of concerns that needed to be reported. Staff said they would look out for changes in people's moods or behaviours to make sure people were protected from harm.

Staff told us they had received training on how to protect people from abuse or harm and were aware of their role and responsibilities in relation to protecting people. Staff training records confirmed staff had received relevant training to support people safely. The provider had a policy and procedure about safeguarding and this linked in with the local authority's protection of adult's procedure. The registered manager told us what action they would take if they suspected abuse. From the information we looked at prior to the visit, we were aware that the provider had reported safeguarding concerns to the local authority and the CQC appropriately.

Medicines were stored safely and securely and there were regular checks in place to ensure medication was kept in accordance with manufacturer's instructions and remained effective. Four medicine administration records showed us people received their medication as prescribed. Appropriate arrangements for the recording of medicines meant people's health and welfare was protected against the risks associated with the handling of medicines. Some people required medication to be administered on an "as required" basis. There were protocols for the administration of these medicines to make sure they were administered safely and consistently in line with guidance from the GP. Staff completed training before they were able to administer medicines and had regular checks to ensure they remained competent to do so. This ensured staff continued to manage medicines to the required standards. Regular medicines checks were completed and where there had been a mistake when giving a medicine, this had been dealt with swiftly. For example further training and checks had been put in place to support the staff concerned.

The provider had plans to ensure people were kept safe in the event of an emergency or unforeseen situations. Fire emergency equipment was checked regularly and staff

Requires improvement

Is the service safe?

knew what action to take in emergency situations. There were records of what support each person required to keep them safe if the building had to be evacuated and this was accessible to the emergency services.

Requires improvement

Is the service effective?

Our findings

People told us they were pleased with the service and they received care and support from staff who had the skills and experience to care for them. One person told us, "Care can be inconsistent when they bring in agency staff who are not fully trained to use the hoist, but they always involve a more experienced carer." Other comments included, "They appear to be kind and well trained, they look after me. You see so many, they change frequently, you don't know their names."

The registered manager and staff spoken with told us an induction supported new staff in the home. The registered manager and dementia services manager, said staff completed training, shadowed an experienced member of staff and then worked with a senior staff member before they worked on their own. We were told there was no pressure for them to work on their own until they felt confident to do so.

Staff told us they received training to meet people's health and safety needs and they had received some training specific to the needs of people, such as caring for people with a dementia. The registered manager used a training schedule to make sure staff received refresher training and where staff required training, plans were in place to ensure it was delivered to them. However, we found further training would support staff in understanding people's needs so they could respond in a more informed way and provide more effective care. For example, one person could be resistant to receiving personal care and become challenging to others. Their care plan did not provide staff with important information and guidance if care had to be delivered. . From speaking with staff, we found most staff had not received training in managing behaviours that could be challenging to themselves and others. We could not be sure staff had the skills and knowledge to effectively support people who could present a risk to them and others.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The MCA protects people who lack capacity to make certain decisions because of illness or disability. DoLS is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe.

Staff received training in the Mental Capacity Act 2005 (MCA) and understood the importance of seeking people's consent before they provided any care. People we spoke with told us staff recognised they wanted to remain independent, which included making their own decisions. One person told us, "I can dress myself but now and again staff help me. My arms ache in the morning." A relative said there is a, "General ethos to allow independence." Staff gave us examples of how they sought consent and how they made sure people had consented before any care was provided. One staff member said, "You talk with them, see how they are and go with their wishes."

Where people lacked capacity to make decisions, the provider recorded information about the support people required. For example, mental health assessments had been completed that showed what some people could not consent to. Where people were unable to consent to certain decisions, they were taken in people's 'best interests' by those closest to them. The registered manager understood the requirements of the Deprivation of Liberty Safeguards (DoLS) and had sought advice from the local authority to ensure people's freedoms were effectively supported and protected. At the time of our visit, one DoLS had been approved. The registered manager was waiting for the results of the other applications submitted to make sure people's liberties and freedoms were not being unnecessarily restricted.

People said they enjoyed the food and we saw they were offered a variety of drinks during our visit. One person we spoke with said, "The food is alright, you get a choice." During the first day of our inspection, we did not see people offered a choice of meals. This was confirmed to us by the dementia services manager although no one could explain why there was no second choice. Staff and the dementia services manager said people were usually offered a verbal choice but we were told the provider was planning to introduce picture cards, so people could make a more informed choice when chosing their preferred meals.

People who had risks associated with poor fluid and food intake had 'food and fluid' charts completed to monitor

Requires improvement

Is the service effective?

their daily intake. These records did not accurately support what people at risk, had consumed. We found staff completed food and fluid charts later in the day and records we looked at showed people had eaten meals that we knew they had not eaten. The amount people had eaten was not recorded either. For example, one relative told us their family member had not eaten their lunchtime meal and only ate a small amount of stewed apple for dessert. We checked the records for this person and a staff member recorded they had eaten roast chicken, mash, gravy and stuffing and for dessert, ice cream. We checked the records for another person who was at risk of weight loss and the records stated the same. This meant staff did not have the correct information to seek the right help or support for people, so the risks to their nutrition were not properly managed.

People told us they saw other healthcare professionals when required. During our visit we spoke with two physiotherapists who assessed a person for mobility equipment Records showed healthcare professionals were contacted when people required specialist support or advice. For example, people were seen by the dietician, occupational therapists, district nurses and the GP. We were told the GP visited the home on a regular basis to monitor people's health and wellbeing, and completed medicines reviews to make sure people had the most appropriate medicine for their health conditions.

Requires improvement

Is the service caring?

Our findings

People were complimentary about the staff who they described as 'kind' and 'caring' and who did their best, despite being busy. One relative told us, "I think they look after her, there's no reason to think not." We spoke with a visiting relative who said the staff were caring because when they visited, "I hear the staff before they see me. I hear what's said and they do care." Some people said they wanted to stay in their room as they preferred their own company and that their choices were respected. All of the people and relatives we spoke with said the staff worked hard to make sure people were cared for. One person said, "They (staff) do care."

From speaking with people and relatives it was clear staff were kind, considerate and caring when they carried out their duties. For example, during our observations we saw friendly interactions with people, and staff spoke respectfully and explained what they were doing as they supported people around the home. People were encouraged to be as independent as possible and do as much as they were able to for themselves. A relative we spoke with recognised staff supported their family member to keep their independence. This relative explained, "They can dress themselves and staff let them, they check to see they are okay. It's good this happens." Other people and relatives we spoke with confirmed staff helped promote their independence as much as possible. For example, at a mealtime, we saw a staff member ask someone if they wanted their food cut up to help them, the person declined and the staff member respected their choice.

Although staff were kind and caring we saw examples where people did not always receive support from staff because time constraints made it difficult for staff to meet people's needs. For example, relatives stressed to us staff were caring, but said staff did not always know people as individuals and did not always take time to find out about them. For example, one relative said it would benefit their family member if, "Staff knew how [person] felt and by spending time with them, would find out why they did not want to do things." This relative explained that their family member stayed in bed for two days because they had no clean underclothes. This relative told us, "When [person] said I am staying in bed, staff did not ask why and left, without asking." This relative said it could put them at risk staying in bed, rather than identifying the issue and resolving it. During the second day of our visit we saw two people had not eaten any of their meal and neither had received any support or encouragement from staff. There were no staff around to help these people or see if they wanted alternative meal choices. Other people we spoke with said there were occasions when staff did not have time to, "Sit and chat."

People told us they were supported with their personal appearance. People wore age appropriate clothes and looked individual in how they were dressed. We noted that people had been supported to express their personality, for example by having their nails painted and some people had this done during our visit. One person we spoke with said they enjoyed having their nails done and another person said they looked forward to visits from the hairdresser. This person said, "I love the hairdresser, I go every two weeks." Staff respected people's privacy and dignity. They understood people's need for personal space and privacy. Some people we spoke with chose to leave doors open, or lock them to keep their personal space secure. When people required assistance with their personal care, it was managed discreetly and behind a closed door. People's bedrooms were individually furnished and the décor had been chosen by people themselves. For example, people furnished their rooms with personal items such as furniture, pictures, photographs and other personal memorabilia.

We spoke with the registered manager and asked them how they were confident staff respected people's choices and supported people in a caring and dignified way. They told us they were regularly on the floor observing staff and seeing how they conducted themselves with people and relatives. The registered manager said, "I watch them and know from the positive comments I get about the staff, they are doing a good job."

People were supported to maintain relationships with those closest to them. Relatives told us the home felt like home because they did not have to wait for staff to take them to see their relative. Relatives said they could see their family member in their room or they could use other parts of the home, for example lounge areas. Staff told us some families used the coffee bar room to hold meetings or reviews, or other events such as for celebrations. We spoke

Requires improvement

Is the service caring?

with two relatives who visited on the day of our visit. We saw they were comfortable in the communal areas and were involved in providing care and support to their family member.

Requires improvement

Is the service responsive?

Our findings

People told us they were happy with the support they received from staff and were complimentary about the staff who provided their care and support. People felt their views about the care they received were listened to. One person told us they experienced episodes of pain and said staff responded by seeking further advice to help manage their health condition. One staff member said they had been monitoring this person's condition and was seeking support from the GP so they could provide better pain management to support their changing condition. Another we person we spoke with said, "I love it here as I have a choice to go anywhere I like."

People and relatives told us they were involved in care planning decisions and reviews which meant people were involved in how they received their care. One person we spoke with explained how their pain levels had recently increased and they informed the staff. We spoke with a staff member who told us they been concerned about this person's wellbeing. They said they had recently asked the GP to review this person's medicines to see if they could have pain relief medicines more frequently. This showed when staff where concerned for people's wellbeing, they took action and acted in a caring and meaningful way.

Relatives said they felt involved in their family members' care decisions and said if there were any changes, they were always informed. One relative said locally Park View had a, "Good reputation and the majority of staff are brilliant." This relative said, "Overall, looking at the big picture I am happy [person] is looked after when I can't be here."

We looked at four care records which described people's needs and abilities and how staff should support them. However they did not adequately record people's individual care needs which led to people receiving care which did not fully meet their needs. For example, from speaking with staff we found inconsistencies in their knowledge of specific people. One person we were told could be challenging and potentially violent in their behaviours, when one staff member said, "The violence is new to me, I have not found it to be an issue." We spoke to two visiting healthcare professionals who visited this person during our visit and they told us they had been informed about this person's behaviours before they went into see them. Incident records and daily records showed when this person displayed challenging behaviours, yet care plan records did not record any behaviours, triggers, signs or information for staff to follow and how to support this person effectively and safely.

We found inconsistencies in care records due to regular reviews not being completed. The registered manager told us they knew some care records had not been reviewed and had set up a care plan audit to regularly check a sample of care records to ensure they accurately reflected people's needs. We were told this was a new initiative and they were in the process of working through all of the care records. Some people and relatives spoken with told us they were invited to care reviews to discuss how they wanted their care and support to be provided. This would help ensure care records continued to support people's individual needs.

People we spoke with said they had a choice in how they pursued their own hobbies and interests. We saw a weekly group activity programme was displayed so people could choose to be involved in group interests such as bingo, visits from singers and arts and crafts. On the second day of our visit, a singer visited the home and sung to a large number of people in the communal lobby. People joined in singing, and some people danced with a staff member. From their reactions we could see people enjoyed this.

We spoke with a staff member responsible for activities who was enthusiastic about their role. They told us they supported people with one to one activities, such as painting people's nails, visiting people in their rooms or supporting people to go outside the home, such as a visit into the local town. This staff member said they recognised if people did not pursue their usual interests and offered people solutions. For example, we were told one person stopped going out to church, so representatives of the church visited the home to conduct services which this person and others attended. This helped people to continue to support and promote their beliefs and cultural backgrounds. A staff member said coffee mornings were held recently to raise money for charity and local people in the community were encouraged to visit the home. As a result of this three people had volunteered from the local community to come in and help with activities, such as playing bingo with people. We asked this staff member if other staff were able to spend time with people on a one to one basis, such as having a conversation. This staff

Requires improvement

Is the service responsive?

member recognised this did not always happen and said meetings were planned with the dementia services manager to improve this area so people received more quality time.

People told us they would talk to staff or the registered manager if they had a concern or complaint. A relative said, "I would speak to the manager if I was not happy." However, people and relatives who told us about their concerns regarding staffing in the home, had not raised these concerns or any other complaints formally with the manager or provider. We saw the provider's complaints policy was accessible to people and people knew how to make a complaint. Records showed that three written complaints had been responded to in accordance with the provider's policy. The registered manager told us they addressed any verbal comments people made, including compliments they received.

Requires improvement

Is the service well-led?

Our findings

People and relatives we spoke with, had no concerns about the quality of care provided although they did share with us their concerns about the staffing levels and how this impacted on the delivery of care. People and relatives were complimentary about the registered manager and said the registered manager was visible and walked the floor on a regular basis. People and relatives said they found the management team and staff very approachable. One person said the registered manager was, "Very good, she is always about."

We spoke with the registered manager who told us, "The home had been through a significant and challenging period." They told us the home had been closed, redesigned and refurbished and had increased from 36 bed to 63 beds. The registered manager explained to us the process and how the project had been managed in terms of moving people and staff from Park View to another home managed by the provider. They told us the move and reopening of Park View was made with people and relatives full consultation which limited potential disruptions and concerns to a minimum.

People and relatives we spoke with said the move was managed extremely well and one relative said, "The transition was seamless." People we spoke with said their new home was lovely and people told us they were comfortable and enjoyed their new rooms and facilities. People and relatives told us they were fully involved and kept updated regarding the progress of the move in services.

The registered manager said the people now living in the home were people from the previous Park View home and some people from one of the provider's other homes where people had stayed on a temporary basis. The staff currently working at Park View was a mix from both of those homes. The registered manager said there had been a period of settling in and they were confident they could address some of the areas they knew required improving. The registered manager recognised the staff dynamics would need time to adjust because they said staff sometimes did things differently. The deputy director of care praised the provider, registered manager and staff team because they worked together to make sure the transition of services did not impact on people and that people were fully involved throughout all stages.

The registered manager acknowledged certain areas needed improvement. They explained, "The move and all that involved has held me back. I need to think about the care we deliver is not task orientated." When we told them about staff comments regarding staffing levels they said, "I need to look at deploying staff and get their feedback." The registered manager said their focus was to, "See how we can make it better." We asked how they would achieve this and they said, "I will ask staff as they are on the floor" and "More clarity in roles between night and day staff." They also said, "I know who can do what now, so I can deploy (staff) accordingly." The registered manager told us they felt supported by the provider and if there was anything they needed, they were able to discuss what they required.

We spoke with staff and asked them if they felt supported by the provider and registered manager. From talking with staff they felt supported if they raised general concerns, but if they raised specific concerns about staffing levels, they said they were not always listened to which impacted negatively on staff morale. One staff member told us they had raised their concerns to the registered manager because, "I don't understand why the numbers drop in the afternoon. They (registered manager) say that's the levels Runwood say are acceptable. I have spoken to our dementia services manager about it." Other staff told us they had raised similar concerns on a number of occasions and had received the same answer which did not address their concerns.

The dementia services manager said the home, "Was on a journey and wanted better." They told us they had noticed improvements required such as "better signage" and how people's choices were presented, such as helping people make more informed choices about food. They said, "We need better accountability so staff know what they are doing." They told us they were working with the registered manager to address this.

People and relatives told us they were involved in making suggestions at the home. We were told meetings were held although minutes of the last meeting had not been completed, so it was difficult to see if actions had been taken. We saw a meeting was planned for people and relatives to attend to discuss dementia and how this affected the person and others. We were told further meetings would be planned to discuss other topics people wanted information on.

Requires improvement

Is the service well-led?

There were systems in place to monitor the quality of the service which were completed by the registered manager and the senior staff. This was through a programme of audits, including checks for care plans and medicines audits. We found some care plans had not been reviewed in line with the registered manager's expectations and they agreed outstanding care reviews would be completed as a priority. Improvements had been made in safe medicines management following increased auditing of records and one to one meetings with staff.

Audits showed some incidents and accidents had been recorded and where appropriate, people received the support they needed. However from speaking with staff it was clear not all incidents had been reported correctly. The registered manager told us they analysed those incidents they were aware of for any emerging patterns and took measures to reduce the potential of further incidents. The registered manager told us they would speak with senior staff to remind them to report any incidents and accidents so their analysis would reflect all of the incidents and any necessary measures could be taken to keep people safe.

There were systems to monitor the safety of the service. We looked at examples of audits that monitored the quality of service people received. For example health and safety, infection control and fire safety. Action plans from each audit were collated to form one plan that the registered manager regularly monitored and updated to ensure improvements had been completed. This helped make sure people received their care and support in a way that continued to protect them from potential risk.

People's personal and sensitive information was managed appropriately. Records were kept securely in the staff office on each floor so that only those staff who needed it, could access those records, so people were assured their records were kept confidential. Staff updated people's records every day, to make sure that all staff knew when people's needs changed although some required further improvement to ensure they were accurate so people continued to receive the right levels of support.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way because risks to people's health and safety were not always assessed and action was not always taken to mitigate risks. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there was sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs. Regulation 18 (1)