Bupa Care Homes (GL) Limited

Park Avenue Care Home

Inspection report

8 Park Avenue
Leeds
West Yorkshire
LS8 2JH

Date of inspection visit:
19 April 2016

Date of publication:
10 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on the 19 April 2016. At the last inspection in March 2015 we found the provider had breached two regulations associated with the Health and Social Care Act 2008.

We told the provider they needed to take action and we received a report setting out the action they would take to meet the regulations. At this inspection we found improvements had been made with regard to these breaches. However, we found other areas where improvements were needed.

Park Avenue is located in the Oakwood/Roundhay area of Leeds. It provides nursing care for up to 43 older people, some of whom are living with dementia. It is close to local amenities and is accessible by public transport.

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 and associated Regulations about how the service is run.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Plans for responding to emergency situations were not fully understood by staff and the policy for resuscitation was not clear on the actions to be taken in the event of cardio-pulmonary resuscitation (CPR.) Staff did not receive appropriate support through a robust programme of supervision to enable them to perform duties they were employed to perform. You can see what action we told the registered persons to take in relation to each of these breaches of the regulations at the end of the full version of this report.

We found improvements were needed to ensure the meal time experience for people who used the service was a positive one. People did not get well organised support at meal times. People did say the food was appetising.

The premises were well maintained to ensure people's safety. However, the environment in the upstairs floor of the home did not always meet the needs of people who were living with dementia. The communal space available was small and cramped.

Relatives of people who used the service said their family members were safe and well looked after at the home. They spoke highly of the staff and the care they provided. Staff had a good understanding of safeguarding vulnerable adults and knew what to do to keep people safe. Staff were recruited appropriately in order to ensure they were suitable to work within the home. They were provided with training to develop their knowledge and skills. However, some staff were not fully aware of the needs and preferences of people who used the service, which meant person centred care was not always provided.

The registered manager and staff understood the requirements of the Mental Capacity Act 2005. The care plans we looked at contained mental capacity assessments where appropriate.

People were supported by staff who treated them with kindness and were respectful of their privacy and dignity. There was opportunity for people to be involved in a range of activities; however, on the day of our visit, there was no provision for people on the first floor.

There were systems in place to ensure complaints and concerns were fully investigated. People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning and improvement.

Overall there were effective systems in place which ensured people received safe care. However we found some records were difficult to decipher due to illegible hand writing within them.

Staff and relatives of people who used the service spoke highly of the management of the home. We observed there was at times a lack of leadership and direction from senior staff in charge of each floor of 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 consistently safe.

The provider had not done everything reasonably practicable to provide safe care in an emergency situation.

There were systems in place to safeguard people who used the service and to ensure people were protected from abuse. Individual risks had been assessed and identified as part of the care and support planning process.

We found the management of medicines was overall, safe. There were enough staff to meet people's needs safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not have the opportunity to attend regular supervision meetings so the provider could not be sure they understood how to deliver care safely and to an appropriate standard.

The meal time experience was not a positive experience for everyone who used the service.

Staff had a knowledge and understanding of the Mental Capacity Act 2005 and demonstrated how they put this into practice. People were supported to access appropriate healthcare services.

Is the service caring?

Good

The service was caring

Staff knew how to treat people with dignity and respect and ensured people's privacy was maintained.

Staff were polite and respectful and overall, treated people as individuals.

There was a pleasant atmosphere in the home. We saw caring interactions when staff provided assistance.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

There was opportunity for people to be involved in a range of activities, however, there were times when some people were not stimulated or occupied which resulted in some distressed behaviour from people who used the service.

Care plans reflected the needs of people as individuals.

People were confident to raise any concerns. Complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

Staff and relatives of people who used the service spoke positively about the management of the home. Our observations showed that at times there was a lack of leadership and direction from senior staff in charge of each floor in the home.

The provider had effective systems in place to monitor and assess the quality of the service provided, however, the records of these needed to be improved to ensure they were legible and easy to understand.

People had the opportunity to say what they thought about the service and the feedback gave the provider an opportunity for learning and improvement.

Park Avenue Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 April 2016 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also reviewed all the information we held about the home, including previous inspection reports and statutory notifications. We contacted the local authority and Healthwatch. We were not made aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted health and social care professionals who were familiar with the service, no concerns were raised by them.

At the time of our inspection there were 36 people living at the service. During our visit we spent time observing the care provision and interacting with people who used the service, spoke with three people who used the service, six relatives and eleven staff which included the registered manager. We spent time looking at documents and records that related to people's care and the management of the service. We looked at six people's care plans and six people's medication records.

The inspection was carried out by one adult social care inspector, a specialist advisor in dementia care and a specialist advisor in nursing.

Requires Improvement

Is the service safe?

Our findings

In the PIR, the registered manager said staff received training in emergency procedures at induction and that the home based trainer and senior staff mentored and monitored staff to ensure they remained competent to provide safe care.

We found eight staff in the home were trained in emergency aid which included cardio- pulmonary resuscitation (CPR). We were told this was updated every three years and staff we spoke with confirmed they had attended these updates. However, we found the equipment in place to support staff to carry out CPR was not suitable. The face mask provided did not have a one-way valve and did not provide adequate nose to mouth seal. Since the inspection we have been informed that this face mask was not in use and has now been removed from the home to avoid being used in error. The registered manager did not have the provider's up to date policy on CPR procedures and a nurse we spoke with said their current training did not advise the use of rescue breath resuscitation and to only carry out chest compressions which was in some conflict with the policy provided to us after the inspection. It was therefore unclear on the procedures that would be followed in the event of this type of medical emergency to ensure people's safety. We concluded there was a breach of Regulation 12 (safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home also had a suction machine with no record of cleaning or servicing or calibration and another machine that did not work. We found the treatment room had a first aid box that only contained four safety pins and a plaster. We drew this to the attention of the nurse on duty for action. The registered manager told us they had recently undertaken a review of these and the other first aid boxes were better supplied.

Staff had received training in the safeguarding of vulnerable adults and the records confirmed this. Staff told us they were aware of their roles and responsibilities regarding the safeguarding of vulnerable adults and the need to accurately record and report potential incidents of abuse. They were able to describe different types of abuse and were clear on how to report concerns. Staff told us they received feedback on any safeguarding concerns to prevent any re-occurrence in the future. The registered manager maintained a safeguarding log which was monitored to ensure any actions needed were carried out. There were effective procedures in place to make sure that any concerns about the safety of people who used the service were appropriately reported.

Staff spoke of their training in managing behaviours that could challenge the service. They said they were trained in de-escalation techniques and felt confident that these techniques prevented incidents of behaviour that could challenge others. However, we noted on one occasion that a staff member providing one to one support for a person who used the service did not have the skills to provide de-escalation techniques when this person displayed behaviours that were challenging to others. We discussed this with the registered manager who agreed that more experienced staff should take responsibility for the one to one support in these circumstances.

Relatives of people who used the service said they felt their family members were safe and well looked after

at the home. One relative said, "It's more than alright here, they look after [Name of person] very well and I have every confidence in them." We saw risk assessments were in place for people who used the service; were appropriately managed and reviewed to ensure people's safety.

There were systems in place to make sure some of the home's equipment was maintained and serviced as required; such as the passenger lift and moving and handling equipment. We saw up to date maintenance certificates were in place. We carried out an inspection of the premises and equipment used in the home. We saw the home was overall, clean, tidy and homely. However, the corridors were narrow and poorly lit in places which increased the risk of trips and falls. We were informed after the inspection that investigations had found the light bulbs did not need changing and that the lights had accidentally been switched from day time lighting to night time lighting.

In the PIR, the registered manager said, 'Staffing levels are reviewed as per dependency and regulations. The home currently has minimum agency usage, with bank staff and our own staff working together as a team, to ensure sufficient staff on duty during periods of sickness and holidays.'

We looked at the last four weeks rotas and found staffing met the planned skill set and staffing level for each floor in the home. All the staff we spoke with said there were enough staff to meet people's needs, and they did not have concerns about staffing levels. Relatives of people who used the service did not have any concerns with the numbers of staff available and their ability to meet care and support needs of their family members safely. Comments we received included; "Always seems to be enough staff, no concerns about that at all" and "Plenty of staff around when I visit, always have time for you." Through our observations and discussions with relatives and staff members, we concluded there were enough staff to meet the needs of the people living in the home. We saw communal areas were well supervised to ensure people's safety and support needs were met.

There were effective recruitment and selection processes in place. Appropriate checks were undertaken before staff began work, this included records of Disclosure and Barring Service (DBS) checks. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.
We saw there were systems in place to record accidents and incidents and monitor for any patterns or trends. The home had found that more falls occurred after 9pm and started a Falls Prevention Action Plan. They had increased night staffing and could demonstrate this had resulted in a reduction of falls.

The home had procedures in place for the safe handling of medicines. Systems were in place to ensure medicines had been ordered, stored, administered, audited and reviewed appropriately. Medicines were securely stored in a locked cupboard and we saw during administration of medicines the medication trolley was locked securely whilst attending to people. We did however find that the topical medications cupboard was dirty and needed cleaning and made the nurse on duty aware of this.

Controlled drugs (medicines liable to misuse) were locked securely in a metal cupboard and the controlled drugs log was completed in full with a running total for stock control. This ensured controlled drugs were managed safely. Medication fridge temperatures were documented daily and within safe limits to ensure medications were stored at temperatures that maintained their effectiveness. Boxed and bottled medications were in date, clean and dry with all names and dosages clear and legible. However, we found there were two boxes of out of date dressings and many loose dressing that were also out of date in the treatment room. These were removed at the time of our visit.

We saw one person was prescribed inhalers and the spacer device used to administer the inhalers was dirty.

There was no evidence this had been cleaned since it was issued in January 2016 to prevent build-up of medication inside the tube and control prevention of infection. We brought this to the attention of the nurse on duty who said they would ensure it was cleaned.

We reviewed six people's medication administration records (MAR). These showed overall that staff recorded when people received their medicines and entries had been initialled by staff to show they had been administered. However, we found there were some gaps and in the main, these had been identified by the service and we saw evidence of actions put in place to prevent re-occurrence. This included staff re-training and supervision. We saw the individual MAR had a photograph of people who used the service with any allergies listed to ensure safe identification.
We observed the administration of medication for a number of people. All were asked for their consent and if they wanted their medications with water or juice. They were given one at a time and checked they had been swallowed. Only after medications were swallowed was the MAR chart signed to say they had been administered.

Some people received PRN (as and when necessary) medication. PRN care plans were in place for medications such as Paracetamol and Movicol. They included when and how to take and the effect the medicine was expected to have, dosage instructions and maximum in 24 hours. For topical medications we saw there was a detailed care plan for administration with pictures showing what, where, why and how the medications should be applied.

Staff who administered medication had been trained to do so. Staff confirmed they received competency checks and the registered manager was aware of the NICE guidance for managing medicines in care homes, which provides recommendations for good practice on the systems and processes for managing medicines in care homes.

Requires Improvement

Is the service effective?

Our findings

At our last inspection of the service in March 2015 we found the service was not fully meeting the legal requirements relating to Deprivation of Liberty Safeguards (DoLS). This was a breach of Regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in April 2016 we found the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 11 described above.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. (The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).) We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that a number of DoLS applications had been made to the local authority and these were being monitored to ensure they were up to date. We saw a DoLS policy and procedure and a Mental Capacity Act policy was in place to guide staff.

We asked staff about the Mental Capacity Act 2005 (MCA). They were able to give us an overview of its meaning and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity or how they made decisions in people's best interests if they lacked capacity. Mental capacity assessments showed how people were assessed and who had been involved in this process to ensure all decisions made were in people's best interests when they lacked capacity to make their own decisions about care needs.

At our last inspection in March 2015 we found staff supervisions and appraisals were not carried out regularly to ensure staff had opportunity to discuss their role and any development needs. At this current inspection, records still showed staff did not receive regular supervision and appraisal. There were gaps of over six months between staff's supervision meetings yet the home's policy stated staff would receive six supervisions per year. The registered manager had a plan in place for staff's appraisals; however 28 of these were overdue. We saw a staff member who had been involved in a disciplinary procedure had not received any documented supervision to support them for nine months. The registered manager had not received any documented supervision for four months. Staff who were responsible for carrying out supervision and appraisal had not received any training in how to do this effectively. We therefore concluded there was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not receive appropriate supervision and appraisal to enable them to carry out their role and ensure competence was maintained.

Staff did however, say they felt well supported by the management team and said communication in the

home was good. They said they had been supported well with personal issues and the registered manager was approachable when they went to them with issues such as staffing and any equipment needed.

We observed the lunch time meal on both floors in the home. On the ground floor we saw this was at times chaotic and disorganised with different staff approaching people; bringing and removing a variety of foods and nobody taking responsibility for a named individual to ensure their needs were met. We observed discussions between staff members as to whether soup had been given to two people; it actually had, however they didn't want it and another staff member took it away. Staff did not communicate well with each other at this time and no leadership was apparent. We observed four staff and five people in the ground floor dining room. It was a pleasant environment with soothing background music played and nicely laid out tables with condiments. People were offered a drink of juice at the start of the meal and a hot drink at the end. We observed white crockery being used to serve macaroni cheese. White crockery often hides these paler foods. If the food is not eaten it can be commonly misunderstood as people not being hungry. Brightly coloured contrasting crockery with large rims and deep insets can help food recognition, and assist with getting the food onto the cutlery. Some people did not eat their meal. The food was home cooked and looked appetising. Menus were written and placed on the table and read out by staff; however pictures would have been beneficial to help people make choices.

On the first floor in the home, there was a communal room which was used as a dining/kitchen and lounge area. This meant that people who used the service were sat for their meal in the same chairs they had been sat in all morning. They were provided with a small side table to eat their meal from. Some people looked uncomfortable and were in awkward positions for eating which meant they spilt food. Staff were patient in the support they gave to people and asked people if they enjoyed their meal. One person did not wish to sit in this communal room and asked to go somewhere quiet. They took a seat by the nurse's station and enjoyed some soup from a beaker. They told us; "This soup's gorgeous, lovely, I'll come here again."

The registered manager told us there had been a recent dining experience audit carried out by the provider's specialist dementia nurse and they were aware they needed to make improvements. Issues identified had included awkward eating positions, too much walking in and out causing distractions and people not being shown the choices of food available. The registered manager had an action plan in place to address the concerns and acknowledged the meal times needed to be better organised to ensure people's nutritional needs were met fully.

We looked at the environment in terms of the provision of specialist care for people living with dementia. The first floor had only one small communal room which was used as a lounge and dining area. With dementia the environment has an important role in the wellbeing of people. It is crucial to create a calm atmosphere which can help to alleviate distress. This one room was not suitable for this purpose and we saw on a number of occasions people showed distressed behaviour due to the effects of the behaviour from others. The registered manager had been in recent discussion with the provider regarding this issue and was waiting to discuss further with them what they could do to improve the environment. The quiet room on the ground floor was very well laid out, with evidence of reminiscence items, to evoke memories. However, staff told us people from the first floor did not use this space.

There was a rolling programme of training available to staff. We looked at staff training records which showed staff had completed a range of training sessions. The training record showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date. Staff told us about the induction training they had completed and said this prepared them well for their role.

We saw people were asked for their consent before any care interventions took place such as assistance with medication or moving and handling. People were given time to consider options and staff understood the ways in which people indicated their consent.

Records showed that arrangements were in place that made sure people's health needs were met. We saw evidence that people had appropriate contact with health professionals such as GPs, dentists, opticians, dieticians and the mental health team. Relatives of people who used the service spoke highly of the health support their family member received and said staff were prompt in seeking medical assistance for them.

Good

Is the service caring?

Our findings

Relatives of people who lived at the home spoke highly of the service. One relative said, "It's marvellous here, they are more than caring." Another relative said, "I find the staff very caring, kind, pleasant and cheerful always." A third relative told us, "They are good carers and I have good communications and consultations with [Name of registered manager]." Relatives told us they liked the staff and got on well with them. In the PIR, the registered manager said, 'All staff at Park Avenue are encouraged to build close supportive relationships with the people they provide care for, including their family and friends.'

Our observations showed staff were kind and respectful in their interactions with people who used the service. We saw staff knocked on doors before entering people's bedrooms and sought permission before giving any care. We did on one occasion see a person ask for staff assistance to get to the toilet, we had to prompt staff regarding this and as the person waited a few minutes for assistance they became distressed. The staff member spoke comfortingly to the person, they said. "It's ok I'm going to help you." People who used the service appeared happy and comfortable with the staff.

In the PIR, the registered manager said, 'Care plans are put in place to ensure that dignity and privacy are maintained, and clients own wishes are documented in agreement with their relatives and relevant healthcare teams. Resident privacy is respected, for example, all staff are expected to knock on doors before entering, doors and curtains are closed when assisting with personal care.'

Staff were trained in privacy, dignity and respect during their induction. The registered manager said they undertook frequent walk arounds in the home to ensure this was always put in to practice.

The relatives we spoke with felt involved in their family member's care and said they were frequently updated on their well-being or changes in care, however this was usually done on an informal basis, rather than a formal review meeting. Relative's comments included; "I feel involved in all aspects of [family member's] care" and "I am kept very well informed on the welfare of my [family member], I have no concerns about mentioning anything to them if I need to."

People looked well cared for, which is achieved through good standards of care. People were dressed with thought for their individual needs and had their hair nicely styled. Staff were confident people received a good standard of care and said they were trained to provide this. Staff we spoke with said they provided good care and gave examples of how they ensured people's privacy and dignity were respected. We observed staff's practice regarding privacy and dignity was good.

The registered manager told us two people who lived in the home currently had an advocate. They were fully aware of how to access the local service and information on advocacy services was on display in the home. The registered manager also told us of people who used an IMCA (Independent Mental Capacity Advisor) to ensure their rights were represented.

Requires Improvement

Is the service responsive?

Our findings

Records showed that people had their needs assessed before they moved into the service. This ensured the service was able to meet the needs of people they were planning to admit to the service. In the PIR, the registered manager said, 'All clients at Park Avenue have a detailed pre-admission assessment, completed by an experienced member of staff, following admission a personalised care plan is developed, documenting how their needs should by met, and any risks to their health and safety is identified and managed.' We looked at six people's care records and found overall these were person centred and provided sufficient detail for staff to meet the individual care needs of people who used the service. We saw the care plans were up to date and reviewed regularly.

In the PIR, the registered manager told us, 'Clients history and life story are encouraged, which is shared with the staff. This enables staff to gain insight and understanding of the clients background and interests, and ensures that care and support meets their lifestyle preferences, cultural and spiritual needs.'

One staff member we spoke with demonstrated a good knowledge and understanding of a person they supported. However, three staff told us they had not yet looked at the care plans and associated documentation of the people who used the service; they were not aware of the life story work. Life story work is a process about getting to know a person and aims to improve their quality of life and wellbeing. It also enables staff to deliver person centred care which can assist in understanding the meaning behind some difficult behaviours people may display. We saw one person's life story information stated they liked a quiet environment yet they were present with staff when a noisy carpet cleaner was being used and became distressed and agitated. The staff member with the person was not aware of the person's need for a quiet environment.

Overall, daily records showed people's needs were being appropriately met. However, on one occasion we saw a staff member completed daily notes when they had not actually provided the care; another staff member had. We brought this to the attention of the registered manager who said they would address this with the staff involved.

The home had an enthusiastic activities co-ordinator who organised a range of activities. Activities were planned and included a whole team approach to ensure all staff participated in activity provision. One staff member said, "We are encouraged to get involved and organise things when [Name of activity co-ordinator] is not here. We saw plans were in place for a special celebration of the Queen's 90th birthday. A relative told us; "We will all enjoy that." They also said, "My [relative] always has a nice time every day in all that they do." Another relative said they thought activity could be more focussed and based on what their relative used to like to do; such as dusting, folding items and setting tables. They said staff tended to just walk up and down with their relative. We also observed this. The person's relative said, "[Family member] ends up with a tired body not mind. When [family member's] mind is tired they will sit quietly and watch the television and [family member] sleeps better."

On the day of our visit we saw people who lived on the ground floor were engaged in a colouring activity

during the morning. The activity co-ordinator and several staff were involved in providing this. We saw some very good hand knitted items were available to stimulate the senses of people who were living with dementia. These included lavender bags to smell and knitted hand muffs with a variety of textures sewn onto them for people to interact with. We saw a number of people used these during our visit. They were left out in the sitting room so people could have easy access to them.

Keeping occupied and stimulated can improve quality of life for the person living with dementia, as well as for those around them. We did not observe any activities on the first floor throughout the duration of our visit. One person who used the service was quite disruptive in the behaviour they presented with on the day of our visit. This was a source of distress for others. We spoke with the registered manager and nursing staff about this and they said plans were in place to address this to make sure the person got the support they needed.

The home had systems in place to deal with concerns and complaints, which included providing people with information about the complaints process. Relatives of people who used the service said they knew who they should complain to if necessary. They said they would not hesitate to raise concerns and complaints. Most said that they would speak to the registered manager. We saw the complaints procedure was on display in the home.

Staff told us they got feedback on complaints in order to prevent re-occurrence of them. We also saw from staff meeting minutes that any feedback on concerns and complaints was discussed with staff.

In the PIR, the registered manager said, 'We have a robust complaints procedure in place, and all complaints are dealt with and responded to within the Bupa complaints procedure. All complaints and concerns are investigated and responded to in whatever form is requested. The outcome may include apologies where there are failures of the home, or if the complaint has raised learning experiences for the home to move forward with.'

We looked at records of complaints and it was clear from the records that people had their comments listened to and acted upon.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection of the service in March 2015 we found the quality assurance systems in place were not effective. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection in April 2016 we found the provider had followed the action plan they had written and overall improvements had been made to increase the effectiveness of their quality monitoring systems.

The registered manager told us they directly monitored the quality of the service in a number of ways. They said this included regular walk arounds in the home; which included talking with staff, people who used the services and any visitors and a daily meeting, known as 'Take 10' with all heads of department in the home. In the PIR, the registered manager said, 'Daily team meetings, regular staff meetings are held to cascade any information relayed from head office, or any issues raised in the home, or initiatives to introduce changes to improve how the service is delivered.'

Quality assurance systems were in place in the home to assess and monitor the quality of service that people received. We saw there was a programme of regular audit which included; care plans, medication, call bell time responses, mattresses, infection control and dignity. Overall, we saw the audits were effective and showed evidence of the follow up action taken to address any shortfalls identified such as mattress replacement, malodours and care assessments that needed to be updated. However, a number of audit records we looked at were at times illegible due to the handwriting, which made them difficult to decipher. The registered manager agreed to address this with the staff team.

We also saw a monthly home review was carried out by the area and quality manager. Records we looked at showed they gained feedback on the service by talking with people who used the service, visitors and staff. They also reviewed a number of records which included, care plan audit outcomes and reviewed the environment. A recent visit in April 2016 had highlighted concerns that the upstairs communal room was too small and there were no suitable tables for people to eat comfortably from. We saw action had been taken and new lap tables had been ordered. We also saw recent correspondence between the registered manager and provider highlighting the need for action on addressing the situation of the upstairs communal room being too small and how this was not meeting the needs of the people who lived at the home. The registered manager said they were awaiting a reply to this. The home reviews showed this room was a recurring theme and had not as yet been rectified.

There were systems in place to monitor accidents or incidents. In relation to learning from accidents and incidents, the registered manager told us that they discussed accidents and incidents at the 'Take 10 meetings' and staff meetings.

There was a registered manager in post who was supported by a deputy manager and a team of care and support staff. Relatives of people who used the service all spoke highly of the management team and how the home was well run. Comments we received included: "[Name of manager], I'd describe her as more than good, very good in fact" and "Very well organised, very good communication; feel you can ask anything, very

approachable and friendly." Relatives said they frequently saw the manager around the home. We did however; observe on both floors in the home there was a lack of direction from the senior staff in charge of the units. Staff were not directed to provide activity or focussed activity for people in receipt of one to one support. Staff were also not well led when providing the lunch time meal.

Staff told us they felt the home was well managed and the registered manager was approachable and proactive. Staff told us they enjoyed their work and felt valued by the management team. We saw staff meetings were held on a regular basis which gave opportunities for staff to contribute to the running of the home. In the PIR, the registered manager said, 'All staff are actively encouraged to approach the manager to discuss any issues, or share ideas on how to improve the service.'

People who used the service and their relatives were asked for their views about the care and support the service offered. The care provider sent out six monthly surveys for people who used the service and their relatives. We looked at the results of the last survey in December 2015 and these showed a high degree of satisfaction with the service. Areas for improvement had been identified, for example, 'promptness of staff attending to needs' and we saw this was monitored by the call bell response audit to ensure improvements. We also saw another area of improvement was 'staff know residents and their needs'. This had not been fully actioned as we found during our inspection that some staff were not fully aware of the needs of the people they supported.

In the PIR, the registered manager said, 'Client and relative meetings are advertised and held quarterly, chaired by the home manager, and supported by Heads of Departments.' We looked at some of the minutes of these meetings and saw people were encouraged to contribute, discuss matters and given the opportunity to express their views and make suggestions. We saw feedback from surveys, CQC inspections and environmental health visits were given. Other topics included menus, involvement in care reviews and hairdressing.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not done everything reasonably practicable to provide safe care in an emergency situation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate supervision and appraisal to enable them to carry out their role and ensure competence was maintained.