Park Vista Care Homes Limited

Park Vista Care Home

Inspection report

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Tel: 01733555110

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Park Vista Care Home is registered to provide accommodation for up to 59 people who require nursing or personal care. The home provides support for older people, some of whom are living with dementia. Accommodation is provided over three floors. The upper floors can be accessed by stairs or lift. The home offers a range of private and communal places where people can relax and receive their guests. At the time of the inspection there were 56 people living at the home.

This comprehensive inspection took place on 10 and 11 January 2017 and was unannounced.

There was no registered manager in place. The provider was in the process of employing a new manager. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

People were not always protected from the risk of dehydration. Records to document and monitor people's fluid intake were not always completed fully or accurately and audits had not been robust.
Systems were in place to assess and manage risks to people using the home. Staff understood the risks for people and staff responsibilities within the home. Information about emergencies was available for staff.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had been assessed. Staff were trained and understood the principles of the MCA and DoLS and were able to describe how people were supported to make decisions if they lacked capacity. We saw that appropriate DoLS authorisations were either in place or had been requested to lawfully deprive people of their liberty. Authorisations in place were for people's own safety because they were unable to make decisions on where they should live safely.

People were kept safe because there was a sufficient number of staff on duty to meet people's needs. The provider's recruitment and selection process ensured that staff had the right skills and experience. Checks were carried out through the disclosure and barring service to ensure that staff were suitable to look after people who lived at Park Vista Care Home. Staff received an induction when they started work and further training which provided them with the skills they needed to meet people's needs.

Staff knew how to support and meet people's needs. People were involved in how their care and support was provided. People had access to health care professionals when they needed them. Staff treated people with care and respect and made sure that their privacy and dignity was respected all the time.

People and staff were able to provide feedback and information so that the provider could monitor and improve the quality of the home. The management team had an open door policy which meant anyone

could make a complaint and make comments or improvements about the care and support provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were kept as safe as possible because staff knew how to protect people from harm and how to report any such untoward incidents. There were sufficient numbers of staff to keep people as safe as possible.

People were protected because risk assessments had been written and followed by staff.

People had their prescribed medication administered by staff who had been trained and were competent to do so.

Is the service effective?

Good

The service was effective.

People were supported to meet their needs by staff who had the necessary skills and competencies.

Staff had received training and understood the principals of the Mental Capacity Act 2005.

People had access to health professionals when they needed them. People had enough food and drink available and were supported by staff to eat and drink where help was needed.

Is the service caring?

Good

The service was caring.

People were treated with respect and staff were aware of people's likes and dislikes. People were encouraged by staff to remain as independent as possible

People had limited activities available but they were involved in the planning of those activities.

Is the service responsive?

Good

The service was responsive.

People had their care needs assessed and staff understood people and how to meet their needs. People were involved in activities that they enjoyed.

There was a complaints process in place and complaints or concerns were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in place.

There were systems in place to monitor and improve the standard of the home. However, audits in relation to fluid charts were not robust.

People and their relatives had the opportunity to be involved in improving and developing the home.

Park Vista 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 home under the Care Act 2014.

This unannounced inspection took place on 10 and 11 January 2017 and was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who is in a nursing home.

Before our inspection we looked at information we held about the home including notifications. A notification is information about important events which the provider is required to tell us about by law. 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 home, what the home does well and improvements they plan to make.

During the inspection we spoke with seven people living in the home, five relatives, the clinical lead, deputy manager, the activities' coordinator, two senior care staff, one member of care staff and one nurse, compliance manager and provider's representatives. We also spoke with two visiting health professionals. We observed how people were being looked after. In addition, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at four people's care records, quality assurance surveys, staff meeting minutes and medication administration records and audits. We checked records in relation to the management of the home such as health and safety audits and staff training records.

Good

Is the service safe?

Our findings

People told us they felt safe in the home although one person said that other people living in the home sometimes entered their bedroom. The person said, "I feel very safe. I get a lot of people [who live in the home] wandering in as my [bedroom] door's open." Another person said, "It's a safe place as a whole. We've got [emergency] bells to ring." One relative said, "We have peace of mind when we're not here." Another relative said, "[Family member] is safe enough – we trust them [staff] 100 per cent."

Staff knew the procedures for reporting any safeguarding and understood their responsibilities in raising any concerns to protect people from harm. One staff member said, "I have completed training in safeguarding and I would immediately tell the senior [member of staff] on duty. And complete a body map if there were things like bruises." Another staff member who had recently raised a concern said, "I reported it to the nurse straight away. They write it up and then report to the manager and to head office." They told us the concern had been dealt with, but stated they knew the telephone numbers so that they would report to the local authority safeguarding team if they were not satisfied. Staff were aware that they could report incidents to senior staff, the provider, or other external agencies such as the local authority safeguarding team. Information displayed in the front entrance of the home gave the contact details of the local authority safeguarding team for people, relatives and staff to use if they needed to. This showed us that people were protected, as far as possible, from potential harm.

We saw that people's risks had been assessed and these were managed to reduce the level of risk where possible. Staff told us about the type of risks that individual people were assessed to have. For example, one staff member told us that people who remain in bed, as the result of their health or through their own choice, were at risk of developing pressure ulcers. Staff told us that they would inform the senior staff or nurses if they found people's skin with red areas. We looked at positioning charts for two people and found that there were details of how frequently the person should be repositioned and this had been recorded and actioned. The clinical lead told us there was no-one in the home who had acquired a pressure ulcer while living in the home. The tissue viability nurse confirmed this and said that staff "pre-empt issues so that we can be alerted early [where necessary]."

There were fire and personal emergency evacuation plans in place for each person living in the home. This ensured people were assisted safely if ever there was a need to evacuate the premises. Staff were aware of where the plans were to be found and told us there were regular fire evacuation tests. The clinical lead confirmed that tests were also carried out so that night staff were aware, too, of the emergency procedures in the home. Records of fire safety checks, water temperatures, equipment such as hoists and wheelchairs as well as air mattresses servicing had been completed. This meant that the home was as safe as possible for people who lived in the home, their visitors and the staff who worked there.

During the inspection we found that there were sufficient numbers of staff available to ensure people's needs were met. However people and their relatives were concerned about the use of agency staff. One person said, "No, there's not enough [staff] generally [on the nursing floor]. I've noticed a big change – a lot of agency staff who haven't a clue what they're doing. They use them a lot at night, both carers and nurses."

Another person said, "There's not enough [staff] on most days. We sit around a lot." Relatives agreed. One said, "They're very short at night, especially. Lunchtimes and bedtime can be very short [of staff] on the floors." Another relative said, "Monday to Friday is better now [name of activities member of staff] is here on activities so there's a 'buzz'. Weekends are terrible for staff, especially Saturday afternoons."

We requested information about the number and type of shifts covered by agency care staff or nurses during 1 to 31 December 2016 and 1 to 6 January 2017. Information we received from the provider showed that there had been two night shifts out of 37 when agency nurses had provided care and three shifts when a member from a care agency was required. This showed a low use of agency staff so that continuity of care was maintained.

The clinical lead and deputy manager told us staffing levels were monitored on an ongoing basis. If extra staff were required to support people whose health needs had increased, then that was done. They stated that there had been a high level of staff sickness recently and there were times that they were unable to find suitable staff cover. We observed during the inspection that staff were available to support people. In addition there were no bells sounding for any length of time, which indicated to us people were being assisted if they called their emergency call bells. However, we were informed on the second day of inspection that the nursing floor was short of one member of care staff. Staff told us they were short on the 'odd time' but the needs of people in the home were always met. One member of care staff said, "They [senior staff] try to find cover and do ring round and use staff from other homes [owned by the provider]. No resident is neglected." We saw that there were enough staff to meet the basic needs for people living in the home. We saw that some areas in the home, such as the lounges, did not have staff situated in them: therefore there were times when there was no staff interaction with people in these areas and even then staff were task focussed. The deputy manager said observations in the lounges and throughout the home would be made to provide evidence of any improvements in staffing levels or organisation that was required.

Accidents and incidents about people had been reported by staff and written on the appropriate forms. Accidents and incidents had been investigated and, where necessary, action had been taken and the outcome recorded. During the inspection, whilst staff were dealing with an emergency incident there were enough staff available to meet the needs of other people living in the home.

We saw that there was a policy in place in relation to recruitment and we checked six recruitment files. We saw that staff only commenced working in the home when all the required recruitment checks had been satisfactorily completed. Staff told us that they had provided a number of documents which included an application form, a disclosure and barring criminal records check and references.

Most people told us they felt that the administration of their prescribed medication was safe. However, during this inspection one person raised some concerns about administration of medication by agency staff that had occurred some months ago. The clinical lead was informed at the time and discussed the problems with the person. They ensured the person had the information they needed to raise their concerns directly, and as soon as possible, if they had any concerns in the future. People told us that staff 'supervised' them when taking their medication. One person said, "They [staff] stay with me [when taking medicines] with a drink." One relative said, "[Family member] speaks up if they are late [to administer their medication]." Another relative told us their family member was given all the prescribed medicines that they needed to keep them well.

We saw that the provider had systems in place so that people's medicines were obtained, stored, administered and disposed of appropriately. Staff told us that only nurses and senior staff administered

people's medicines, although topical medicines, such as creams and ointments, were administered by care staff. Where one or two tablets (such as paracetamol) could be taken, staff had recorded the number given. This meant staff followed the provider's policy on medication recording. Protocols were in place for any prescribed medication that could be taken 'as necessary'. We checked the stock of medicines and medicines administered against people's Medication Administration Record (MAR) charts and found these were accurate. Where medicines had not been administered, the reason for this had been stated on the reverse of the MAR chart. This meant people were receiving their medicines as prescribed.

Good

Is the service effective?

Our findings

People and their relatives told us they felt that the permanent members of staff had the necessary skills to meet their needs. However, they commented that the agency staff were not as knowledgeable. One person said, "Some [staff] are very good, but the agency [staff] ones [are] not always great." Another person said, "Ours [staff] are fine and know what they're doing. The agency [staff] not." One relative said the staff seemed 'very capable'.

Staff told us they felt supported in their role and there was a positive approach from the provider to their learning and development. For example, the activities co-ordinator said they had recently completed training through the National Activities Provider Association. They told us that they had found the course "interesting" and had also attended a conference in relation to people living with dementia. One senior carer told us they were undertaking paramedic training the following week and they were looking forward to that.

Staff confirmed that areas of training expected by the provider, such as moving and transferring people, safeguarding, infection control and medication administration were provided and updated where necessary. Staff also said further training in relation to their roles could be requested and that it would be provided. We saw the training plan for 2017, which showed the different training courses that staff were expected to attend as well as designated courses such as taking blood samples and end of life care. The deputy manager also said that sessions, such as teaching staff how to write care plans and daily notes, were ongoing.

The provider told us that all new staff would be expected to complete the Care Certificate. This training includes a set of standards that social care and health workers must apply in their daily working practice. One new member of staff told us they had completed a basic induction programme when they first started working at the home. This had included time in the office to look at policies and procedures and shadowing a more experienced member of staff and getting to know the people they were to care for and support.

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.

Staff confirmed they had received training in the Mental Capacity Act 2005 (MCA) and understood how these principles were to be applied to ensure people's human and legal rights were respected. Staff showed us pocket note cards which had the five principles of the MCA. They told us they would refer to these as a reminder when considering people's capacity to make decisions. One member of staff said, "You [staff] can't say if someone has or does not have capacity [in all areas of their life].You cannot assume. You have to look at their best interests." They went on to explain that people could make poor decisions, "just like we do", but also said they would discuss things with other staff to make sure they acted within the legislation. Another member of staff told us how they ensured that they obtained people's consent before providing care. They

gave an example and said, "We [staff] ask if it's okay if we come and wash you or dress you. Some people decline or ask for you to go back later, which is what we do."

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

People told us, and care records confirmed, that they had access to health care professionals. One person said, "I get the chiropodist every six weeks and had the optician in a while back [some time ago]." However, another person also said there had been a difficulty getting a dentist as none came into the home, although a relative was now trying to access one in the community. People were supported to gain access to other health professionals. One relative told us that their family member had had a mental health assessment (through the mental health community team). Another relative told us the speech and language therapist (SALT) had assessed their family member. Care staff told us that, when needed, they informed the senior person on duty who would call a doctor if necessary. One person told us, "They're [staff] good at getting the doctor in."

People's care records showed that their dietary needs were assessed, monitored and where required referrals made to the appropriate health professionals. For example, where a person had been identified as having a swallowing difficulty, this had been referred to the SALT team and arrangements made to assess their swallowing. One relative said their family member had recently had another SALT assessment and said, "We've had some good tips. [Family member] has pureed food now and it's amazing how they shape it [the food] to look like the real thing – very effective." We spoke with the chef who was able to tell us about the dietary needs of people and their likes and dislikes.

We spent time with people in the dining room at lunchtime. People were told what the menu was for the meal and staff checked that people were happy with that. Staff told us, and we saw, that people would ask for an alternative such as a sandwich, baked potato, salad or omelette. People were assisted with their meals if they needed it and we heard how staff asked people if they would like their food cut up. Where people needed help to eat their meal we saw that there was good interaction and people were not hurried when the help was given. We noted that other people received discrete observation from staff and encouragement to eat when necessary. We saw that one person, who was reluctant to eat, was offered to have their meal in a smaller lounge as the staff realised that they had found the dining room too noisy. The person was also told by a member of staff, "You say what you fancy and I'll get it for you." People commented, "I like my meals in the lounge. I get asked what I'd like", "The food is average. I don't get a choice at lunch but we do at tea. They'll make me a sarnie [sandwich] of a night if I want" and "We can ask for a snack any time." One relative said the food was not always hot. They said that the main course on the day of inspection was not warm enough but the pudding had been hotter. The relative also made a positive comment that staff had assisted their family member by cutting the person's food because of an injury.

People and their relatives told us there were always drinks available. One person said, "I've got my jug of squash and the tea trolley comes up a few times a day as well." Another person said, "I have my brandy and whisky for the odd tipple. I get plenty of squash and the tea trolley visits too." One relative told us that staff had listened to them about the way to provide fluid for their family member and said, "The kitchen [staff] are going to try and create the same 'sloppy jelly drinks' that the family provided from home.

Good

Is the service caring?

Our findings

Overall people told us that staff were kind and helpful. People told us, "They're generally very kind" and "I'm kind to them and they're kind to me." Relatives told us, "You can't fault the 'caringness' of them [staff]", and "They're [staff] genuinely caring carers." Another relative said, "They [staff] have a very good attitude – nothing is ever too much trouble." Two visiting health professionals said they felt staff were very caring, attentive to people's needs and supportive (to the health professionals).

We spoke with staff and they were able to tell us about individual people. They told us about people's current needs, what they were able to do for themselves and how they communicated if there were issues about language or understanding. One member of staff said, "I love my job. The main thing is making people laugh. I'm always smiling. I love listening to their [people's] stories." The staff member was able to tell us about the care one person needed as well as their interests. These included word search puzzles, looking at their photo album, eating biscuits and being able to see their clock. This demonstrated that staff knew about people and the care and support they required.

People and their relatives told us they felt involved in the planning and making decisions about their care. One person said, "They [staff] did the first assessment with me and asked lots of questions." One relative said, "We don't usually have meetings as I'm in every day anyway and talk to staff." Another relative told us that staff kept them informed and said, "[Family member] is under the social care team with the council so we have meetings with his social workers here too." We also saw evidence in people's care plans that they were involved in discussions about end of life care and one relative said, "We feel quite involved and can discuss changes and ideas. We were concerned about the subject of end of life care but [name of family member] has had a good conversation with us and we're clearer." Information in people's files showed that they or their relatives had been involved in their care plans and reviews.

People told us they felt comfortable with the staff who looked after them. There were comments such as, "They [staff] make me feel comfy to be around" and "I find them good with me and we have a chat and put the world to rights." Relatives agreed and one commented, "[Family member says [they] feel at ease with them [staff]."

People and their relatives told us the staff encouraged them to remain as independent as possible. One person said, "They definitely let me do as much as I can without help." A relative told us, "They let [family member] try and wash [their] face to help [maintain their independence]. The rest they have to help [family member] with." People told us that staff did respect their privacy and dignity. There were several comments that staff knocked on people's bedroom doors and waited until the person asked them to come in. People said things such as, "They knock and let me say come in, even with the door open", and "They respect my privacy when I'm in my room." Relatives also agreed that staff were "Respectful of [family member] and very good on the dignity side," and "They [staff] certainly don't barge in. They understand [people's] privacy."

At the time of our visit the majority of people had relatives or friends who acted on their behalf when necessary. One person told us, "The family have Lasting Power of Attorney so do the legal things."

Information displayed in the front entrance of the home gave the contact details of advocacy services if people did not have someone to act on their behalf. Advocacy services are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

We received mixed views from people about the care they received to meet their individual needs. One person told us, "I'd like them [staff] to come and give me a wash and help dress if I need it. They've not enough time in the day to be with you – quick in and out." Although a relative said, "Since [Family member] has been here [family member] hasn't looked back and the care has been great. [Family member is] happy and the staff are marvellous with [family member]."

We looked at four people's care plans which provided adequate information about the person's needs. The deputy manager said that care plans were being changed and showed us the new format which provided more information to reflect how people were to be supported on a daily basis. Staff were able to tell us about people they supported, their care plans and knew how to meet people's individual needs.

Staff told us information was shared, so that they were kept up to date about changes in people's needs. For example, one member of staff said, "[Daily staff] handover provides information about people's health as well as the care plans, diary and handover sheets." This meant that relevant health or care information was handed over to staff coming on to shift and the information was documented. Staff also told us they regularly sat with people to review the information in their care plans to ensure the information reflected their current needs.

People were very complimentary about the activity co-ordinator but felt the availability of activities was limited at times and not always inclusive. During the inspection we saw that people were sat in lounges with only the television for stimulation. We undertook a SOFI which we discussed with the deputy manager during the inspection. Observations we made were in areas where we saw staff were not always as inclusive in conversations with people as they could have been and at times very task focussed (although the care for the individual was very good).

In the afternoon some people were encouraged to take part in a colouring activity. The activity co-ordinator said another co-ordinator was being employed so that activities would take place every day of the week but were not in place yet. They also commented that a lot of people enjoyed individual time and that was limited by the time available when trying to provide activities for everyone living in the home. One person said, "No-one comes up [stairs] but I'd like it if someone [staff] could play cards or do a quiz and things. I look forward to going out with my family once in a while, to the park or to the shops. No-one here has got time to take me (out) for some air." Another person said, "They have people come in and sing and we do a church service once a month." The provider had their own transport and one person told us that they did go "out in the van (transport provided by the provider)" for a coffee or a trip. We saw that there were weekly tea parties held in the home a Scottish piper was coming for Burns night later in the month and a new entertainer as well. People had also commented that there were quizzes, chats with the co-ordinator and that she also painted their nails. People and their relatives told us if they did not want to take part in activities, their decision was respected. One relative said, "We've seen the 'red book' with the list of activities in it. They seem to have the odd thing on like a tea party or church service. [Family member] has not been to anything yet but they do ask [family member]."

People and their relatives told us they knew how to make a complaint and who they would speak with. People told us about a range of complaints where some issues had been resolved to their satisfaction and other complaints investigations were ongoing. One person told us, "I'd talk to the carers if I had a worry." Relatives told us about issues with stoma care, cold meals and clothing going missing from the laundry. We spoke with the deputy manager and clinical lead about some of the concerns. They immediately went to discuss the issues with the people concerned to resolve them as soon as possible.

Staff said they were aware of the complaints policy and knew how they would help people o make a complaint if they wished. One member of staff commented, "I would write concerns in the complaints book, which is accessible. I would sit with the person and get them to fill in the form or [I would] write it if they wanted. I believe it [any concern] would be followed up." There was evidence that complaints had been responded to and investigated. Where necessary there were discussions with individual members of staff and refresher training given where appropriate. Information was shared with other staff so that the provider could improve and learn from issues that had been raised.

Requires Improvement

Is the service well-led?

Our findings

We could not be assured that people received adequate fluids. This was because the records that were used to document and monitor people's fluid intake were not always completed fully or accurately. We noted that, although there were details of the expected fluid intake for a person during 24 hours, on some days staff had not totaled the input or had totaled them incorrectly. This meant that for people at risk of dehydration there was an increased risk to their well-being. However, staff told us people were provided with drinks but the amounts given were not always recorded. We spoke with one health professional who said they had no issues with people's skin integrity at this time. We spoke with the deputy manager and clinical lead who immediately placed hourly requirements for staff to provide and record fluid for people who required it. We saw that this had been completed when we visited the following day.

At the time of our visit, Park Vista Care Home did not have a registered manager in post. The last registered manager left the home in October 2014. There was a deputy manager and clinical lead in place to manage on a day to day basis, supported by representatives of the provider and a compliance manager who also covered quality and education. Information from the provider's representatives was that a new manager had been appointed and they were in the process of obtaining the relevant checks. An application to register as manager at Park Vista Care Home would be made as soon as possible.

People, told us that the home was, "A quiet place really," and "It's got a good feeling." Relatives said that they felt the atmosphere in the home "depended which staff were on duty", although overall it was "happy enough". People and their relatives were generally positive about the management team being visible and approachable. One person said, "[Name of clinical lead] is good but I don't see them up here. She gets things done." One relative said, "They're brilliant, very approachable. [Name of clinical lead] is very efficient." One person said, "[Name of deputy manager] is excellent. They [management team] do their best." Two visiting health professionals both agreed that there had been improvements in the home, one saying, "It's definitely on the up." The other commented that even small changes, such as being welcomed at the door and being shown to the person they were to visit, made a difference.

Staff were able to explain who in the management team was responsible for the different areas in the home as well as the provider's representatives. Staff told us the provider's representatives came into the home regularly and they had their contact details so were able to speak with them directly, if they needed to. Staff were aware of the provider's whistle blowing policy and said they would be listened to and action would be taken if necessary. One member of staff said they were not sure what support would be in place for the whistle blower but the concern would be investigated. They said they would look at the policy again to ensure they knew what support was available.

We received a mixed response when speaking with people about meetings they could attend. Some people were not aware there were any meetings, whilst others told us they attended and there had been positive results. One relative said, "They had one meeting so I went and enjoyed it and got a copy of the minutes too. They listened to us and I learnt some things too, like how we can look in the red book [which contains activities that have happened as well as future events]." Another relative told us there was a meeting 'in a

few days', and said that "at the last one there were staff, residents and relatives. They keep the minutes brief and we get to see them." We saw that there was a meeting due on 18 January 2017.

The last meeting for people and their relatives was on 25 August 2016. Information in the minutes showed that people had been listened to and where possible things had been put in place. For example, there were discussions about Christmas activities and the entertainment discussed such as hand bell ringers and a choir from the local school. These had been provided. People had raised the issue of staffing levels and the manager (at the time) explained how the staffing ratio worked. There had been discussions about the laundry and people and their relatives were asked to ensure that items of people's personal clothing were labelled and to check clothing that had been found as unlabelled, in the laundry. People were asked to request staff to record any new clothing on their clothing inventory. People and their relatives were informed that if they had any questions at any time they could speak to staff. People were informed during the meeting that there were to be new photographs of plated meals so that people who were unable to communicate verbally would be able to make choices for themselves. We saw that this was in place during the visit.

Minutes of staff meetings showed these took place on a regular basis. There were different meetings for day and night staff so that as many staff as possible would be able to attend. Staff told us that the meetings were an opportunity to discuss any issues or concerns. One staff member said that during the meetings there was also the chance to talk about topics and then discuss them, such as the changes in how accidents were recorded. We saw that staff agendas provided time for staff to raise any other business. The meetings were also used as a forum to ensure that staff understood what was expected of them. Good practice sessions and lessons learned from events and incidents were shared at these meetings. For example, the provider's Health and Safety person attended the meeting on 19 December 2016 to discuss risk assessments, but also to praise staff for 'their hard work during the recent outbreak of diarrhoea and vomiting'.

The new compliance manager, who was responsible for quality assurance and staff training, showed us the new system of audits she was putting in place. Monthly visits started in December 2016 so that observations were made, together with checking the robustness of the previously completed audits. A subsequent action plan was being developed to improve the home based on the compliance manager's findings.

People were encouraged to feedback their experience of living at the home and to raise any issues or concerns they may have had. People and their relatives told us they talked with staff on a day to day basis. Relatives made comments such as, "They [staff] do listen to me and take notes too", "Definitely, they take on board what we say," and "Very much so – I can ask them anything." On the day of inspection the activities co-ordinator was assisting people to complete a questionnaire about the standard of the service that they received. The activities co-ordinator told us the information was sent to head office to be collated and any action, that may be needed as a result, would be given to the management team. One person told us, "I've not had one [questionnaire], but I see the staff every day anyway to ask things." Another person told us they had completed the questionnaire the day before.