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Parkview Care Home

Inspection report

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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?	Good

Summary of findings

Overall summary

This inspection took place on 30 April and 01 May 2018 and the first day was unannounced. We last inspected the home on 22 and 23 September 2016. The provider had breached the regulations relating to person-centred care; risk assessments had not been personalised to the needs of each person and some were out of date. Some care plans were not up to date and others lacked personalised information to ensure people received appropriate care.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Effective, Responsive and Well-Led to at least good. At this inspection we found the provider had taken remedial action and was now meeting the requirements of these regulations. The provider of this service was archived on 29 June 2017 when the name of the provider changed, however the provider of the service and location remained the same.

Parkview is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Parkview Care Home is registered to provide nursing care to older people; the home can accommodate up to 24 people and accommodation is provided over two floors with lift access. The home has 21 bedrooms for single occupation and three can also accommodate two people if required. Some bedrooms have en-suite facilities and some rooms are for communal use including the lounge, dining room, conservatory, bathrooms and shower rooms. At the time of our inspection 17 people were living at the home.

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

People living at Parkview told us they felt safe. Staff we spoke with understood the principles of safeguarding adults, including how to report any concerns they had and a safeguarding log was maintained. Staff were aware of the provider's whistleblowing policy and procedure.

There were policies and procedures to guide staff about how to safeguard people from the risk of abuse or harm. Staff had access to a wide range of policies and procedures regarding all aspects of the service.

Safe recruitment practices were followed to ensure appropriate staff were employed at the service.

People had a variety of risk assessments in place in order to keep them safe which identified specific areas of concern.

Medicines were managed safely and stored securely and were administered in a person-centred way. Competency assessments for staff who administered medicines were carried out.

Equipment used by the home was maintained and serviced at regular intervals. The home was clean throughout and there were no malodours. The environment was suitable for people's needs.

The provider used a tool to identify people's dependency levels to ensure enough staff were on duty. This tool determined the number of staff hours required to meet individually assessed needs.

Staff followed infection control procedures and wore appropriate protective clothing.

Staff received appropriate induction, training, supervision and appraisal and there was a staff training matrix in place.

The provider had a contingency plan in place for any emergency event, for example lift failure or loss of utility supplies and appropriate checks on the premises and equipment had been completed.

Accidents and incidents were recorded and audited monthly to identify any trends and prevent future re-occurrences. The home had been responsive in referring people to other services when there were concerns about their health.

People told us the food at the home was good. There was a seasonal menu in use and this was displayed. People's nutritional needs were monitored and met.

When people had undertaken an activity this was recorded in their care file information and there was a range of activities available for people to choose from.

The service aimed to embed equality and human rights though good person-centred care planning and people were provided with a range of useful information about the home and other supporting organisations.

People told us staff treated them well and respected their privacy and dignity. We observed positive interactions between staff and people who used the service.

Care plans were now more person-centred and included information on what was important to the person. Staff sought consent from people before providing support. People's health needs were managed effectively and there was evidence of professional's involvement.

The service was supported by other relevant professionals when providing end of life care. Several relatives had commended the home for the quality of its end of life care provision.

There was a complaints policy and procedure in place. This clearly explained the process people could follow if they were unhappy with any aspects of their care. There was a service user guide and statement of purpose in place.

Formal feedback from people who used the service and their relatives was sought and there were regular meetings for people to attend.

The service worked in partnership with other professionals and agencies in order to meet people's care

needs.

There was an up to date certificate of registration with CQC and insurance certificates on display as required. We saw the last CQC report was also displayed in the premises as per legal requirements.

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.

Medicines were managed safely.

People told us they felt safe living at the home.

There were safe procedures for the recruitment of staff and sufficient numbers of staff on duty.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times.

Care plans included appropriate personal and health information and were up to date.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us staff were kind and caring.

Staff attitude to people was polite and respectful and people responded well to staff interactions.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Care plans were up to date and contained relevant information.

Care plans were person-centred, well organised and easy to follow.

Positive comments were received regarding the provision of end of life care.

Is the service well-led?

Good

The service was well-led.

Audits and quality assurance checks were carried out regularly.

Staff felt the home was well-led and told us the registered manager supported them well.

People were asked for their views about the service and the culture of the service was focussed on the needs of people who used the service.

Parkview 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 checked 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 30 Aril and 01 May 2018 and the first day was unannounced. The inspection team consisted of one adult social care inspector and expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert was experienced in older adult's residential, community and dementia care.

Prior to the inspection we did not ask the provider to complete a Provider Information Return (PIR). This was because the provider had already sent us this document in December 2017.

During our inspection of Parkview Care Home we spoke with the registered manager, the deputy manager, and four members of care staff. We also spoke with 11 people who lived at the home and two visiting relatives. This was to seek feedback about the care being provided at the home.

We looked in detail at four care plans and associated documentation, supervision and training records, four staff records including recruitment and selection records. We also looked at audits and quality assurance, a variety of policies and procedures, medicine administration records (MAR's), safety and maintenance certificates.

We undertook 'pathway tracking' of care records, which involved cross referencing people's care records via the home's documentation. We observed care within the home throughout the day in the lounges, dining room and communal areas.

We observed the medicines round and the breakfast and lunchtime meal. We looked around the premises including garden and people's bedrooms. We also reviewed previous inspection reports and other information we held about the service. We used this information to inform our judgement about the service.

Good

Is the service safe?

Our findings

People living at Parkview told us they felt safe. One person said, "I feel safer than where I have been before, it is more personal." A second person told us, "If you are concerned you just press the buzzer, someone comes quickly." A visiting relative commented, "Doors are monitored; if you have any concerns, the staff do their best to resolve it." A second relative said, "[Person name] has had more accidents in her previous flat, that's why I feel she is safer here."

Staff we spoke with understood the principles of safeguarding adults, including how to report any concerns they had. Staff knew about various types of abuse and told us they would report any concerns to the registered manager. Training records confirmed staff had completed safeguarding training. One staff member told us, "I've done safeguarding training and it's all about keeping people safe in their environment and ensuring they are well looked after. I would report any concerns I have to the manager or the local authority if they were not available." A second staff member said, "Safeguarding is about protecting people and making sure they are safe; I've done training in safeguarding but never been involved in any. I would tell the manager if I had any concerns."

The provider maintained a safeguarding log which confirmed that one recent safeguarding concern, which was an altercation between two people who used the service, had been referred to the local authority safeguarding team as required and investigated fully.

Staff were aware of the provider's whistleblowing policy and procedure and told us although they had not had to report bad practice, but they would have no hesitation in doing so if they were concerned about a person's safety. One staff member said, "I know about whistleblowing and wouldn't hesitate to raise any concerns I have."

People had a variety of risk assessments in place in order to keep them safe. These included assessments for falls, skin integrity, dietary needs, communication, memory and cognition, safety within and outside the building, moving and handling, bed safety, personal hygiene and bathing, malnutrition, medication, cardiac and respiratory issues. This helped ensure guidance was in place for staff on minimising risks to people's wellbeing and safety. The risk assessments were reviewed and updated when changes occurred.

Medicines were managed safely and stored securely; including checks on room temperatures being completed to ensure the effectiveness of medicines was maintained. MAR charts were all completed accurately and we saw the staff member administering medicines completed people's MAR charts correctly after they had administered the medicines.

We observed medicines to be administered in a person-centred way, for example one person had a limiting healthcare condition which affected their cognition and fine motor skills. We saw the staff member explained to the person what each medicine was that was being offered and asked them if they wanted to take the medicine themselves or with staff assistance. When this was established the staff member ensured the person was ready to accept the medicine and offered it in an un-rushed manner, which was in keeping

with the person's care plan information, and offered the person a drink and a tissue to wipe their mouth following administration. This allowed the person to have maximum control and input when taking their prescribed medicines.

Medicines due for disposal were stored safely and people told us they received their medicines as required. The service used the British National Formulary (BNF) book which is pharmaceutical reference book that contains information and advice on prescribing medicines. Competency assessments for staff who administered medicines were carried out, which was confirmed by staff we spoke with; a competency assessment allows the manager to determine if staff have the correct skills and knowledge.

The provider used a tool to identify people's dependency levels to ensure enough staff were on duty to safely care for people living at the home. We saw the staff on duty matched with the number required by the tool to support people fully. The registered manager was aware that people's needs could change over time and this could affect their dependency levels.

We looked at staff rotas and confirmed staffing levels remained consistent which meant the provider had systems in place to monitor staffing levels and ensure continuity and familiarity with people who used the service.

We asked people if they felt there were enough staff on duty. One person commented, "There is always someone around." A visiting relative said, "I feel there are generally enough staff; I am here almost every day, though at times it's a while before staff respond to the buzzer."

We checked infection control procedures and observed staff practice. Staff had access to personal protective equipment such as gloves and aprons. We saw all areas of the service were clean, and there were no malodours in any of the communal areas or bedrooms we checked. Staff used best practice infection control procedures when cleaning floors to ensure that cross contamination was minimised.

Safe recruitment practices were followed to ensure appropriate staff were employed at the service. All potential staff were required to complete an application form and attend an interview so that their knowledge, skills and values could be assessed. The provider undertook checks on new staff before they started work. This included checking their identity, obtaining references from previous employers and/or character references and Disclose and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Appropriate checks on the premises and equipment had been completed, including the mains electrical installations, gas supply, the working order of the lift, portable appliance testing (PAT), hoists, equipment and legionella. These checks ensured the building was safe for people living at the home. Fire equipment was checked and practice fire drills were carried out. A fire risk assessment was in place.

The provider had a contingency plan in place for any emergency event, for example lift failure or loss of utility supplies.

Good

Is the service effective?

Our findings

We asked people who used the service if they felt staff had the correct skills and knowledge to provide effective care to effectively meet their needs. One person said, "Staff here don't skive, they don't talk over you, they're always talking to you." A second person told us, "When you need someone, staff are always there day or night."

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 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).

At our last inspection we made a recommendation that the provider researched and followed current guidance in relation to the Mental Capacity Act and took action to update their practice accordingly; this was due to a local delay in processing applications when the local authority had not assessed some of the DoLS applications previously submitted. We also found a decision had been made regarding the trialling of a specialist bed which had been discussed with nurses and family members, but there was no evidence of a MCA assessment and best interest decision having been made.

At this inspection 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.

At the time of our inspection, there were a number of people living at the home who had a DoLS authorisation in place and there was no evidence that people were being deprived of their liberty unlawfully. An up to date DoLS tracker sheet was kept which identified the date the application was submitted, the date authorised and the date of expiry. A renewals list was now also kept which demonstrated the service had correctly re-referred people to the local authority prior to the expiry of their existing authorisation. We saw that people's capacity to consent to their care was captured on the initial assessment. If people had a power of attorney (POA) or an advocate, this was captured in people's care files. All the staff spoken with were aware of their responsibilities under the MCA; they knew how people communicated their wishes and how they showed they consented to their support. The provider was aware of advocacy services if needed.

We looked at staff training and saw there was a staff training matrix in place to demonstrate courses and topics undertaken by staff. We saw staff had access to a range of training including manual handling, infection control, health and safety, risk assessments, fire safety, safeguarding, MCA/DoLS and equality and diversity. Staff we spoke with confirmed they had completed this training which we also verified by looking at historical training records held by the service.

Staff were required to undertake a probationary period before being offered a permanent position, which included observed practical assessments before confirmation in their role. Staff were also required to familiarise themselves with the people using the service by reading care plans and spending time in their company. If a new staff member had not previously worked in social care, their induction was aligned with the requirements of the care certificate.

One staff member said, "I had an induction when I first starting working and did some shadowing shifts with other staff. At the end I had an assessment and was signed-off as being competent." A second told us, "It's been a while but I had an induction at the beginning and remember reading policies and procedures and care plans and doing training plus shadowing some shifts. We get regular training and refresher training and observations of practice."

We found staff received supervision every eight to 12 weeks or more frequently if required, for example if a staff member had taken on additional responsibilities or changed their job role, they were provided with additional supervisions to help them develop in their new role. We looked at the staff supervision file and saw each supervision record demonstrated the registered manager tailored the supervision to the individual staff member's needs. There was a staff supervision matrix in place with dates identified for the year and annual appraisals were undertaken for each staff member.

We observed the lunch time meal to help us understand how well people were supported. We saw tables had been set with table cloths, cutlery and jugs of squash. Staff supported people into the dining room where they sat at tables in small friendship groups of three to four people. Most people were independent with eating and drinking and in the morning all people had been asked what they wanted to eat that day, with staff explaining what was on the menu so people could make their own choice; the meals appeared to be appetising and warm.

We observed staff supporting two people at mealtimes. This was done in an unrushed manner and at a pace suitable to the people concerned. We saw staff communicated well with people and encouraged them to take part and do as much as possible for themselves, in accordance with their care plan information. The daily menu was on display and people told us they enjoyed the food provided. People commented positively about the meals and comments included, "They look after us well, we get fed very well," "If you don't fancy roast dinner, they give you something else," "I am very particular about my food, that's why I simply prefer to have a chicken or tomato soup," "They provide you with lots to drink throughout the day, such as fruit juice and tea," Somebody comes in to ask what you want to eat, and you tell them." A visiting relative commented, "I have seen food being served, it appeared nice."

We found people's nutritional needs were monitored and met and their weights were regularly monitored and action taken if staff were concerned about any significant weight loss. Allergen information was identified and any allergies recorded. The home had achieved the highest possible score of five following a recent environmental health inspection by Manchester city council.

The environment was suitable for people's physical needs. There were hand rails in corridors, grab rails in toilets and bathrooms, pressure relieving items and sufficient moving and handling equipment. There was some signage for bathrooms/toilets, the dining room and other areas of the building, which would assist people living with a dementia to better orientate around the environment.

The home's furnishings were observed to be neat and tidy, bedrooms, corridors, toilets, floors and other utilities were dust free and odourless. The lift was in a working order and all stairs and exit points were free from trips hazards.

People were able to personalise their bedrooms with individual items such as family photographs, bedding and personal objects and there was adequate space and seating in each bedroom for visitors to use and spend private time with their relative. One person told us, "They said they are getting a new carpet, but I don't think they need one, they must have spent lots of money making the place up already." A second said, "I love my bedroom, it has new carpets and has been painted."

People's health needs were managed effectively and there was evidence of professional involvement, for example GPs, podiatrists, district nurses, speech and language therapy (SaLT), dietetic advice, chiropodists or opticians where appropriate. This demonstrated people had access to health care professionals when required.

Staff recorded in each person's care file when they had been visited and treated by health care professionals. One person told us, "I was told I have a chest infection, the doctor has been to see me and I am waiting for my cough mixture." A second person said, "When I am not well, I see my GP and it is all thanks to staff kindness; getting me some help before I could be worse." A third commented, "Staff are Godsend, if I am not well, they make me well." A visiting relative told us, "They always keep me updated if [person name] is under the weather. A second relative said, "I was informed fairly quickly when [person name] fell and we suspected she had fractures; but she had not sustained any fractures."

We observed several instances when district nurse attended the home to attend to people in accordance with their assessed needs, for example to administer injections or to assess them for specialist equipment which indicated people were provided with the appropriate type of health care support, when this need was indicated.

Good

Is the service caring?

Our findings

People we spoke with commented positively about the attitudes and approach of the staff group. One person said, "It's alright staying here, I've been here since my last care home was closed, at least the people are friendlier." A second told us, "I like it here, the atmosphere is very homely." A third commented, "People respond, let's say, favourably to your needs; I was staying in a room at the back and staff moved me here so I can be close to everybody else."

A visiting relative told us, "The place is just right for [person name]. We have been to lots of other places, this one my mum loves it, she has never been better, but the other reason why I brought my mum here is because of what the home represent, as it is stated in the front, the carers come in to care and this is the residents own home." We determined this comment was in relation to a staff notice that was placed on a board which held pictures of each person and their room number, the notice stated, 'Our residents do not live in our workplace, we work in their home.' This statement demonstrated respect for people living at the home and gave clear guidance to staff on the approach to take.

People were treated with dignity and respect and told us they were listened to. Comments from people we spoke with included, "If you need to go somewhere, staff will take you; I tell them where to take me," "Carers are nothing but caring and respectful," "Carers always ask if you are ok and if you need anything," "The carers are helpful, you can't ask for any more than that," "The carers are fantastic in the way they look after us," "They do everything for me, they are very kind, but I still tell them what cardigan I want putting on."

We looked to see how the provider promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights though good person-centred care planning. Support planning documentation used by the service enabled staff to capture information to ensure people from different groups received the help and support they needed to lead fulfilling lives, which met their individual needs. For example if people had been referred to the home who required an alternative diet the service had responded appropriately.

We found there were appropriate policies in place which covered areas such as equality and diversity, confidentiality, privacy and dignity.

We found people and their relatives were involved in developing their care plans. We saw people were provided with information about the service and there was information about likes, dislikes and preferences in care files for how care should be carried out which demonstrated people and their relatives had been involved in decisions about planning their care and support.

We found staff had developed a good rapport and understanding of the people living at the home and staff were friendly towards people and treated them with courtesy and respect. We observed staff interacted with people well and engaged them in conversations relevant to them. We saw staff took time to stop and talk to people, to offer them drinks or to provide reassurance and support. We saw many other instances when staff greeted people as they got up in the morning at a time of their own choice, enquired about their welfare and

then confirmed with them if they were having breakfast.

One staff member told us, "The home was presented with a 'dignity in care award' in 2008 and we intend to keep the standards," which indicated their commitment to providing a caring service.

People were encouraged to maintain relationships with people that mattered to them and there were no prescriptive visiting times, and we saw several relatives visited the home during the inspection. We saw people chatting with relatives or staff or amongst themselves in the dining and lounge areas and communication between people who used the service was constant, with people enquiring about other people's welfare or what they were doing that day.

The home had received compliments from people who used the service and their relatives. Comments included: 'Thank you so much for making Parkview [person name's] home and for looking after so well and for you friendship and kindness;' 'You all do a very difficult job under challenging circumstances, [person name] was very grateful to you all;' 'A very big thank you for keeping our mum safe and for the kindness you have shown whilst she has been with you.'

Good

Is the service responsive?

Our findings

At our last inspection, we found care plans were not always detailed enough or up to date to reflect people's current needs, other care plans lacked detailed information to ensure care staff provided consistent care and support and risk assessments were not always personalised to the individual needs of each person. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to person-centred care. At this inspection we found the provider had taken remedial action and was now meeting the requirements of this regulation.

At this inspection we found the provider had started evaluating all care plans which were now reviewed each month or as needs changed and personal preferences and choices were now better identified in people's care files. We found the process of evaluating all care plans was on-going and some care plans still needed to be re-written in parts in order to be more person centred and evidence relative and resident involvement.

One care plan stated, 'I like to settle at 9.30/10pm. I have a profile bed and also an upgraded mattress. Staff check that my mattress is working properly and leave water in my room.' We looked at daily records for this person, which recorded what had happened each day and found care had been provided as stated in their care plan.

We asked people and their relatives if they were involved in developing their care plans. Although not everyone we spoke with could remember if they had been involved, others told us they had been. One person said, "I do recall someone talking to me about how I am doing." A second person told us, "A man came last week to talk about my care." A visiting relative commented, "I have been informed when people come to discuss mum's care."

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We found the provider was meeting this requirement by identifying, recording and sharing the information and communication needs of people who used the service with carers/staff and relatives, where those needs related to a disability, impairment or sensory loss.

Prior to people moving into Parkview Care Home, an assessment of their care needs was carried out. Some people who had been referred to the home by the local authority also had local authority assessments in place. The assessments included mobility, eating and drinking, communication, capacity, cognition, medication, personal care and moving and handling.

Each person also had their own personal care plan which detailed their care needs and the kind of support they required from staff; these included support with personal care, nutrition, senses and communication, mobility, oral health, podiatry, personal safety, cognition, social interests and family involvement. If people's care needs had changed, we saw these were updated to reflect things that were different. This meant staff had access to important information about people's care requirements.

Staff we spoke with understood the principles of person centred care, one staff member said, "Person centred care is about providing care that is specific to that person and you get satisfaction from helping people to be well looked after."

People told us staff were responsive to their needs. One person said, "Carers know what I like, I don't tell them how much sugar I need in my tea, they know it already." A second person told us, "Thank God staff know when to give me my tablets, if it was me, I wouldn't know when and what to take."

We saw the home was responsive to people's care needs and requirements. For example one person had been referred to the home in an emergency situation and although the home had initially accepted this referral based on information received and in order to provide support to alleviate the immediate emergency situation, the registered manager had immediately recognised that the overall environment was not suitable for this person's longer term needs and had been proactive in contacting their social worker in order for them to be reassessed with a view to identifying a more suitable home.

We found were opportunities for people to participate in a range of activities. Staff showed us two activities diaries for 2017 and 2018 which both featured pictures of people enjoying various activities in singles and in groups such as, dancing during music entertainment, birthdays and themed parties, enjoying some exercise, having bingo fun and games, visiting local shops and having pub lunches, themed music events and film days. There were planned activities for each day of the week.

Although there was no dedicated member of staff for activities, staff members we observed were keen to keep people mentally and physically stimulated. This was confirmed by one staff member who commented, "We wouldn't be caring for our residents properly if we did not encourage them to keep active and therefore allowing them to use whatever abilities they have left." Comments received from people regarding activities were positive and included, "I like watching telly and getting up dates about what's happening out there," "I like it when people come in to sing for us," "I like to come in here and share some sort of conversation with friends, we are all friends," My daughter takes me out every week, she takes me to local markets," "I go to day centre for activities twice a week, we do lots of things, play lots of games and make friends."

A visiting relative confirmed activities were provided regularly and told us, "I have seen people playing bingo, throwing balls and doing exercises."

The provider followed the nationally recognised 'Six Steps' end of life programme to support people with making advanced decisions about their future care needs. Care records showed people had been given the opportunity to discuss their wishes, which were recorded in their care files. The registered manager kept a register to identify at which of the six steps people were currently at. There was an up to date end of life are policy in place to support people and provide guidance to staff.

A complaints policy and procedure was in place which allowed people to express if they were dissatisfied with any aspect of the service they received. We looked at the log of complaints maintained and saw an appropriate response had been made to any complainant. People we spoke with told us they knew how to make a complaint if they had any concerns and guidance telling people how to make a complaint was displayed. People who we spoke with and their relatives all confirmed they knew how to make a complaint but had not had any reason to do so. Comments included, "If I was not happy, I will let carers know, I can speak for myself," "I never have to make a complaint; staff are doing their best for anyone." A relative said, "I do know what to do when I am not happy about something or someone, and it is called telling the boss."

Good

Is the service well-led?

Our findings

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 the registered provider, they are Registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection we found the provider did not have an effective system of care plan audits in place and this was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to good governance. At this inspection we found the provider had taken remedial action and was now meeting the requirements of this regulation.

Care files were now reviewed each month and a tracker sheet was used to ensure all care plans were reviewed in a timely way. There was also a 'resident of the day review' document in use which included a check on health, mobility, diet and nutrition, personal care, room check, medical appointments and professionals visits, end of life care and residents views on the quality of care. This ensured a thorough check of all documentation and information was now carried out for each person on a rolling basis.

We looked at the systems in place to monitor the quality of service being provided to ensure good governance. Audits and checks included care plans, safeguarding, accidents and incidents, infection control, mattresses, wheelchairs, hoists, medication, health and safety, nurse call-points, equipment, complaints and staffing levels/competencies. This would help management to identify any concerns within the service and act on them in a timely way.

Staff we spoke with told us management were always present and visible in the home and said management supported them well. Our observations throughout the inspection confirmed this view and we observed the management team were involved in supporting and advising staff and people who used the service throughout the inspection. The registered manager displayed a positive approach throughout the inspection when accommodating our requests for information and answering our questions.

One staff member told us, "The team is very happy and I feel well supported. Staff meetings are happening regularly and these are useful because we can discuss issues and we get the meeting notes afterwards." A second said, "I like the amount of support I get from the manager and we work as a team. I'm very happy with the atmosphere. The manager is always available of you need them and will listen to me and sort things out. The manager has made some positive changes and she always explains why. Team meetings and supervisions are happening regularly."

We looked at the notes from previous staff meetings and found discussions included management changes and new staff, staff rotas, medication, record keeping, fire safety, health and safety, nutrition, infection control, dignity and respect and safeguarding.

Records of meetings with people who used the service and their families identified discussions had included

dignity and respect, safeguarding, bedrooms, new furniture, end of life care, outings and entertainment.

Formal feedback from people who used the service and their relatives was sought through annual quality assurances surveys, via formal meetings, as part of the review of care plans and through the process of daily feedback. We looked at the surveys undertaken in 2017 with people and their relatives and found comments were overwhelmingly positive. Feedback had also been gained from community professionals who visited and supported the home.

Feedback from people who used the service indicated they were very satisfied with: the choice, variety and amount of food provided; the effort made to satisfy individual needs, the attitudes of staff; social activities and home decoration. One person told us, "The manager, oh yes she's great; she's lovely." Another person said, "The managers look after us, they solve our problems."

Similarly feedback from people's relatives showed they were very happy with: the quality of the home's personal and social care; the quality of the food; the quality of activities; equality and diversity; connections with the local community; freedom of choice; the safety of relatives; the atmosphere within the home; staff competencies. One comment said, "A very high standard of service and care for the residents."

Feedback from a healthcare professional referred to the most impressive aspect of the home being 'personal care, relationships with people and individualised care.'

The registered manager commented, "I make sure I hire good staff; if they are not entirely here for the residents they can't work here and my rule is 'no mobile phones and no talking over the residents' full stop"

The previous inspection report was on display in the home along with a range of other useful information for people who may be considering a placement in the home. Each person was provided with a 'service user's guide' which included information about the service and staff and how to make a complaint. A Statement of Purpose was also made available to people which is a legally required document that includes a standard set of information about a provider's service.

The registered manager had been proactive in submitting the required statutory notifications to the CQC and a log of all notifications was in place. Confidential information was being stored securely and we saw records such as care plans and staff personnel files were stored in the office when not in use.

The service had a business continuity plan that was up to date and included details of the actions to be taken in response to an unexpected event such as the loss of utilities supplies or loss of premises and equipment. This meant that in the event of an unforeseen disruption to the service there were robust plans in place to provide continuity of support people using the service in a safe and co-ordinated way.