Crystal Nursing Services Limited

Park View Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected the service on 26 and 27 July 2016. The inspection was unannounced. Park View Nursing Home is registered to provide accommodation for up to 14 people with learning or physical disabilities. On the day of our inspection 11 people were using the service.

The service had a registered manager in place at the time of our inspection. 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.

Risks were not always assessed and planned for appropriately and medicines were not always managed safely. Seating in the service was not always clean.

People were supported by staff who knew how to recognise abuse and how to respond to concerns. People were supported by enough staff to ensure they received care and support when they needed it.

People were supported to make decisions but the Mental Capacity Act 2005 (MCA) was not always applied consistently in the service to protect people who did not have the capacity to make certain decisions. People were supported by staff who had the knowledge and skills to provide safe and appropriate care and support.

People were supported to maintain their nutrition and staff were monitoring and responding to people's health conditions.

People's diverse needs and methods of communication were not always assessed or planned for. People and their relatives were involved in making choices about the care and support they received. People were supported by staff who cared about the individual they were supporting. People were supported to enjoy a social life.

People were involved in giving their views on how the service was run and there were systems in place to monitor and improve the quality of the service provided. The registered manager knew what improvements were needed in the service and were working towards these.

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.

Risks to people were not always assessed and planned for appropriately. Seating in the service was not always clean and hygienic and medicines were not always managed safely.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents.

There were enough staff to provide care and support to people when they needed it.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People made decisions in relation to their care and support but the Mental Capacity Act 2005. (MCA) was not applied consistently to protect people who did not have the capacity to make decisions for themselves.

People were supported by staff who received appropriate training and supervision.

People were supported to maintain their nutrition and their health was monitored and responded to appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's diverse needs and methods of communication were not always recognised or planned for.

People's were supported by staff who cared about the individual they were supporting. Staff respected people's rights to privacy and treated them with dignity.

Is the service responsive?

Good

The service was responsive.

People were involved in making choices about their care and support and were supported to have a social life and to follow their interests.

People were supported to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Good

The service was well led.

People were involved in giving their views on how the service was run.

The management team were approachable and recognised where improvements were needed in the service. There were systems in place to monitor and improve the quality of the service.

Park View Nursing 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.

We inspected the service on 26 and 27July 2016. The inspection was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved in the service and commissioners who fund the care for some people who use the service. 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.

During the visit we spoke with five people who used the service. Some people who used the service had limited verbal communication and some were out so we also relied on observations and spoke with the relative of three people to get their views.

We spoke with three members of support staff, a qualified nurse and the registered manager. We looked at the care records of three people who used the service, medicines records of seven people, recruitment records of six staff, as well as a range of records relating to the running of the service including staff training records, audits carried out by the registered manager and registered provider.

Requires Improvement

Is the service safe?

Our findings

When we last inspected the service in January 2015 we found there was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safe recruitment checks were not always being followed when new staff were employed. We asked the provider to send us an action plan telling us when they would make improvements to this. They sent us an action in April 2015 saying they had made the required improvements and had implemented a system so this would not occur again.

During this visit we looked to see if the improvements had been made and we found the action had been completed. The registered manager had implemented a checklist to ensure all staff files contained the required information and that all checks of staff prior to recruitment had been carried out. Before staff were employed the registered manager had carried out checks to determine if staff were of good character and requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. References had also been sought from the previous employers of staff. These checks are to assist employers in maker safer recruitment decisions. This meant the required steps had been taken to protect people from staff who may not be fit and safe to support them.

Risks to individuals were assessed and plans were in place to minimise these risks. However the plans were not always up to date with accurate information and steps had not always been taken to mitigate the risk. For example, one person was at risk of falling out of bed and records showed they had fallen in their bedroom on two occasions recently. The care plan for this person stated there were bed rails in place to prevent the person falling and an alarm to alert staff if the person got out of bed. However neither of these were in place. We spoke with the registered manager about this and they informed us they thought it might be due to the bedrails posing a further risk to the person, however alternative methods of mitigating the risk of the person injuring themselves if they fell out of bed had not been explored.

We found that not all areas of the environment were clean and hygienic. We saw that a specialist chair used by one person had a high level of food and drink debris and the sofa in one lounge had food debris stuck to the inside of the arms. We saw the housekeeper kept a record of the cleaning they did, however these did not include the cleaning of specialist equipment and the deep cleaning of the sofa's and staff said this was the night staff responsibility. Additionally the housekeeper did not work at the weekends meaning that staff undertook cleaning during the weekend and also when the housekeeper was on holiday. There were no schedules in place for what the staff should clean during this time and no records kept to show the cleaning had taken place. Infection control audits had not taken place since April 2016 and so these issues had not been identified.

People had been assessed as not being safe to administer their own medicines and so relied on staff to do this for them. Two people we spoke with told us that staff gave them their medicines when they were supposed to and that these were given at the same time each day.

However, we found the medicines systems were not always safe. On four days in the week prior to our visit the temperature of the room where medicines were stored had risen above the safe recommended

temperature. Staff had not reported this to the pharmacy to check if any of the medicines would need to be replaced. When medicines are stored above the recommended temperatures there is a risk they will not be as effective. The registered manager told us they would deal with this and that there were plans to move the medicines to a cooler room a few days after our visit.

Records showed staff were administering medicines to people as prescribed by their GP. However one person had not been given their medicines on the first day of our visit due to them having a seizure and being asleep. Staff had not reported this to the person's GP to ascertain if it would be safe for the omission of these medicines.

We saw staff were following safe protocols in relation to carrying out audits of the medicines and taking action to address any areas of concern. Staff received training in the safe handling and administration of medicines and had their competency assessed prior to being authorised to administer medicines.

People were protected from abuse and avoidable harm. All of the people were spoke with told us they felt safe. One person told us they felt safe with staff because they supported them to go out as the person didn't feel safe on their own. They went on to say, "my confidence has grown because of feeling safe." The relatives we spoke with also felt their relations' were safe in the service. One relative told us, "[Relation] would let me know by crying if [relation] was unhappy there."

People were supported by staff who recognised the signs of potential abuse and how to protect people from harm. Staff had received training in protecting people from the risk of abuse and staff we spoke with had a good knowledge of how to recognise the signs that a person may be at risk of harm and to escalate concerns to the registered manager or to external organisations such as the local authority. Staff were confident that any concerns they raised with the registered manager would be dealt with straight away.

There were risk assessments and care plans in place detailing how to support people to be safe both within the service and in the community. For example one person needed specialist headwear when they were out of bed., We saw this was described in their care plan and we saw the headwear was being worn during our visit. There were also plans in place detailing how to safely support people with moving around the service, for example if they needed a hoist.

People were living in an environment which was maintained to keep them safe and protect them from risks.The registered manager told us in the PIR that there were weekly reviews of the safety of the environment and maintenance of the building with daily observation checks and a recordable system for any issues or concerns identified. We saw there were systems in place to assess the safety of the service such as fire risk and the risks of legionella. Staff had been trained in relation to health and safety and how to respond if there was a fire in the service. There were plans in place detailing how to support individuals in the event of an emergency such as a fire.

People received the care and support they needed in a timely way. People we spoke with told us there were staff available if they needed support. The relatives we spoke with also felt there were enough staff working in the service to give their relations the care and support they needed. One relative told us, "There's always somebody on each floor to help." Another relative confirmed this by saying, "I think that they have enough staff for what they need." On the day of our visit we observed there were a number of staff available to meet the requests and needs of people. Staff were readily available to support people when they needed or requested it and staff were also available to escort people in the community.

The registered manager told us that no one in the service had one to one staffing and that there was a

baseline of between five and seven staff. They told us staffing levels were increased when more staff were needed, for example for social time away from the service. There had been changes made to the staffing levels at night with one member of staff being nominated as emergency call, to escort people to the hospital in case of an emergency. Staff we spoke with said they felt there were enough staff to meet the needs of people who used the service.

Requires Improvement

Is the service effective?

Our findings

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.

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. The registered manager understood their role in relation to the MCA and staff we spoke with had a basic understanding. However, we found the MCA was being applied inconsistently. For some decisions there was an MCA assessment with a record of what decision had been made in the person's best interest. However we found the best interest decision record was not always being recorded and so it was unclear what decision had been made. For example two people had an assessment in place which detailed they did not have the capacity to decide about voting but there was no record to show what decision had been made in relation to this. One person had not been assessed to decide if they had the capacity to make decisions about whether they followed their culture and so their preferences had not been planned for. This meant that people who lacked the capacity to make certain decisions were not being protected under the MCA.

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 saw the registered manager had made applications for people who they felt might be having restrictions placed upon them due to them not being safe to leave the service alone. This meant people were not being restricted without the required authorisation.

People were supported to make decisions on a day to day basis. We observed people decided how and where they spent their time and made decisions about their care and support. People told us they spent the day as they wished to and decided what they did and how they spent their time.

People were supported by staff who were trained to support them safely. All of the relatives we spoke with said they felt staff knew what they were doing. One relative gave examples of how the staff dealt with their relations behaviours and anxieties. We observed staff supporting people and saw they were confident in what they were doing and had the skills needed to care for people appropriately.

Staff we spoke with told us they had been given the training they needed to ensure they knew how to do their job safely. They told us they felt the training was appropriate in giving them the skills and knowledge they needed to support the people who used the service. We saw records which showed that staff had been given training in various aspects of care delivery such as safe food handling, moving and handling and infection control. Staff told us that if they needed any additional training they could ask the registered manager and they felt this would be arranged for them.

People were supported by staff who were enabled to gain the skills and knowledge they needed when they first started working in the service. Staff were given an induction when they commenced their employment. The registered manager told us that new staff were completing the care certificate and one member of staff we spoke with confirmed this. The care certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

People were cared for by staff who received feedback from the management team on how well they were performing and were also able to discuss their development needs. Staff told us they had regular supervision from the registered manager and were given feedback on their performance and the registered manager confirmed this in their PIR.

People were protected from the use of avoidable restraint. People who sometimes communicated through their behaviour were supported by staff who recognised how to avoid this and to respond in a positive way. There were plans in place informing staff of how people's behaviour should be responded to both in the service and in the community. The plans gave details of what may trigger the behaviour, how it would manifest and how staff should respond. Staff were also given training in relation to responding to behaviour using least restrictive methods.

People were supported to eat and drink enough. We spoke with people about the food and they told us they had enough to eat and we observed people had access to food when they wanted to eat. One person told us, "You can eat what you want." Another person described how the chef was patient in trying to find the correct type of food for them and said, "I can request foods to be sent up and stored in the fridge to eat later at night."

One person had a Percutaneous endoscopic gastrostomy (PEG) fitted to provide a means of nutrition due to them not being able to eat orally because of a risk of choking. The nurses had recognised the person may be able to eat orally and involved specialists to assess this. This had resulted in the person gradually being introduced to eating food orally and we saw this had a positive impact on the person who was clearly very excited when they sat at the dining table and ate. We saw there was a detailed care plan in place to guide staff on the person's nutrition in relation to the PEG and oral food and fluid.

There was information in people's support plans detailing their nutritional needs which were regularly assessed. Records showed that staff had responded when one person's appetite had changed and they had lost some weight. Staff sought advice from the dietician and we saw staff were following the advice given. For example recording what the person ate and assessing their weight more frequently.

People were supported with their day to day healthcare. People who used the service told us they felt their health needs were met in the service and relatives we spoke with also confirmed this. One person told us, "If I feel unwell I would tell a member of staff and if necessary a doctors or dentist appointment will be made." We saw people were supported to attend regular appointments to get their health checked with their GP and the dentist. Where people had ongoing health conditions they were supported to see specialists on a regular basis.

The registered manager told us in the PIR that the service had effective relationships with the local GP who visited every 6 weeks, along with community services such as physiotherapists regularly visiting the service. Records showed that staff sought advice from external professionals when people's health and support needs changed. For example staff had involved a physiotherapist for one person when their mobility changed. We saw there was a range of external health professionals involved in people's care, such as

occupational therapists, epilepsy team and the Speech and Language Team (SALT).

Requires Improvement

Is the service caring?

Our findings

People's diverse needs were not always assessed and planned for. One person who used the service belonged to a particular culture. This would mean the person needed to be supported in a specific way in relation to how they dressed, in their personal care and attending religious services. The person had a cultural care plan in place; however this just gave reference to the person's culture and did not provide staff with any detail on how the person should be supported. For example this person's culture meant they should only be provided with personal care from a specific gender but this was not detailed and one member of staff was unaware of this need. We spoke with the person's relatives and they told us staff would support the person to attend religious services when the relatives requested it. However the person was not being supported to attend these services on a regular basis.

People's individual methods of communication was not always recognised and planned for. One person was limited in their verbal communication. There was a care plan in place which stated the person could use some sign language, however the plan did not detail which signs the person could use or what they might be trying to communicate. Staff told us about a few signs the person used to communicate but these were not written in the person's care plan to enable other staff to learn what the person was communicating. Picture cards had not been used to try and ascertain if the person could communicate using these and to develop them and build on their communication skills.

People we spoke with told us they were happy living at the service. One person said, "I am happy. I like it here." Another person described how the staff were encouraging and could lift their spirits when they felt low and said, "They (staff) really are very patient." Another person told us, "I like it here, I have got friends." A third told us, "Very kind staff."

The relatives we spoke with were positive in their comments and said they felt the staff were caring and compassionate. One relative described the housekeeper knowing people's needs, describing to us how their relation communicated through behaviour and said the housekeeper would, "Clean bedrooms at the appropriate times as not to cause further anxieties." Another relative told us, "The staff are great, really good. They (staff) seem to care as much about [relation] as we do."

We observed staff interactions with people and we saw staff were kind and patient with each person when they were supporting them. Observations and discussions with staff showed that staff clearly knew people well and recognised when they were unhappy. We saw in people's care plans that their preferences for how they were supported were recorded, along with details about their life history. One relative complimented staff by saying, "From what I've seen they (staff) know the residents."

People we spoke with told us they got to make choices; for example about when and where they ate, how they spent their time and what activities they did. We observed people's choices were respected on the day of our visit. We saw that one person said they didn't want to eat in the service and wanted to go out for lunch. This was arranged and the person was supported to go out to the place they had chosen. We observed lunch and saw people had chosen what they wanted to eat and were provided with the food of

their choice. One person told us, "There's a menu but if you don't like it, you can ask for something else." People could either eat in the downstairs dining area or upstairs in the kitchen diner. There had been some renovations to provide people with more seating areas to choose from, such as a quiet lounge being added on the second floor and an additional seating area in an annex off the downstairs lounge. We observed this had created more space for people to use and this had resulted in a calm atmosphere throughout the service.

We saw that activities were chosen by the people who used the service and records showed that people were encouraged to speak up if they wanted to do any particular activities. People were also able to choose where they would like to go on holiday. We saw that people had bedrooms which were personalised to their tastes. Care records contained information to ensure staff knew which choices people were able to make themselves and which they would need support with.

People told us they could have visitors whenever they liked and relatives we spoke with confirmed this. Relatives told us that staff were proactive in supporting people to maintain contact with their family. We were told about some people who used the service being supported to visit their relatives in their homes whilst other relatives visited Park View. There were no undue restrictions to visiting, with relatives being made to feel welcome.

The registered manager told us that no-one was currently using an independent advocate to support them with decision making but that they would be supported to if and when needed. We saw there was information displayed in the service, in a format people would understand, detailing how to contact an advocate. This meant that people had access to advocacy services when they needed it. Advocates are trained professionals who support, enable and empower people to speak up.

People were supported to develop independent living skills. Drink making facilities had been introduced to the downstairs dining room and we observed one person using this when we visited. There was a new kitchen/diner upstairs and this had been designed to support people who used the service to make themselves drinks and snacks and to learn to bake, cook and do their own laundry. On the day we visited an external service attended the home to support people to learn cooking skills. One person was prompted to answer the door of the service when the doorbell rang. The registered manager encouraged this saying, "It is your home."

People were supported to have their privacy and were treated with dignity. People we spoke with told us they felt staff respected their privacy and dignity. Relatives also spoke positively about this. One relative told us, "They treat [relation] as an adult, making sure they get choices." Another relative said, "[Relation] always looks clean, tidy and smart." We observed people were treated as individuals and staff were respectful of people's preferred needs. Staff were mindful not to have discussions about people in front of other people and they spoke to each person with respect. There were care plans in place for individuals detailing how staff should support them with their personal care, ensuring their privacy and dignity was respected.

The registered manager told us in the PIR that during recruitment interviews, potential staff were asked to talk about their personal values and what they considered to be unacceptable behaviour. Records we saw confirmed this to be the case. The registered manager told us the management team carried out observations to ensure staff were respectful of people's privacy and dignity. Staff we spoke with showed they understood the values in relation to respecting privacy and dignity and had received training in relation to this. We observed staff always knocked on people's doors prior to entering and were discreet when discussing issues of a personal nature.

Good

Is the service responsive?

Our findings

People and their relatives were involved in making choices about their care and support. People told us they were given autonomy to decide what time they got up and went to bed and how they spent their day. One relative commented that they felt involved in making decisions in their relations' best interests. Another relative said that the staff kept them informed of any changes in their relations health. They told us this could be from phone conversations or meetings. They said that they felt listened to in meetings and were asked for their opinions about the care and support of their relation. The registered manager told us in the PIR that people who used the service were invited to care reviews and had their opinions noted.

The registered manager told us they were currently working on implementing additional supplementary care plans which were less health focused and more centred on people's preferences and their goals and aspirations. We saw one of these which was in progress and saw the plan had been written with the person who it was designed for to ensure they were involved in the plan.

People were supported by staff who were given information about their support needs. We saw that people's care plans contained information about people's physical and mental health needs and guided staff in how to support them. For example one person had epilepsy and we saw there was a clear detailed care plan in place guiding staff in how to respond to any eventuality of the seizure such as what to do if the seizure lasted for more than what was considered normal for that person. We saw staff followed the guidance on the first day we visited when the person had a seizure.

Where people had limited mobility there were assessments and care plans in place detailing how staff should support the person to reduce the risk of them developing a pressure ulcer. There were also detailed care plans in place in relation to people's long term health conditions such as diabetes. We saw the plans were followed in practice and people were supported with their health conditions.

People were supported to follow their interests and take part in social activities. People had been supported to get involved in a variety of activities such as horse riding, social clubs, walks in the park, music sessions, art and crafts, along with regular attendance to day centres and life skill clubs. Park View also offered a selection of in house activities. An external organisation was visiting several times a week to deliver interactive sessions to develop people's skills in relation to areas such as cooking and art work. We saw people's art work was displayed throughout the service, giving people a sense of achievement.

On the first day we visited some people were going horse riding and two other people were supported to go out into the community. On the second day we visited one person was supported to take part in daily living skills training, one person went to the day centre and three others were supported to go out into the community. We spoke with the driver employed by the service and they told us about people being supported to go to a local social club and other events in the community.

People knew what to do if they had any concerns. The people and relatives we spoke with told us they would speak to one of the management team if they had a problem or concern. They told us they felt they

would be listened to.

The registered manager told us they had received one complaint since the last time we inspected the service. We looked at how this had been dealt with and found it had been recorded and acted on appropriately by the clinical manager. Staff were aware of how to respond to concerns and there was a complaints procedure in the service so that people would know how to escalate their concerns if they needed to.

Good

Is the service well-led?

Our findings

People we spoke with told us they were happy living in the service and the relatives we spoke with also commented positively on the service. One relative said, "We work as a team." Another said that they felt the management was open and transparent and felt listened to, with any issues being resolved. We received feedback from a visiting professional and they told us that the management team and staff they had dealt with had been very friendly and helpful. We saw there had been some compliments recorded from visiting health professionals commenting on how helpful staff in the service were when they visited.

There was a registered manager in post. People we spoke with knew who the registered manager was and we saw they responded positively to him when he was speaking with them. The registered manager was open and accessible to people who used the service. We observed people entered the office on many occasions and sat and had discussion with the registered manager during our visit. We found the registered manager was clear about their responsibilities and they had notified us of significant events in the service.

The registered manager was open to feedback from visiting professionals and was clear in his vision of the future for the service. He described improvements the management team had made such as renovating parts of the environment. He recognised the work which was still needed and was passionate about working with the clinical manager to move the service in a new direction.

Staff we spoke with told us they felt there had been improvements in the service since we last visited. They felt the management team worked well together and complimented each other in the way they worked. One member of staff told us, "It is early days but the home is moving in a new direction." We saw that a health professional had commented at a review of a person who used the service that they felt the person had improved since moving into Park View.

People who used the service, their relations and other visitors were given the opportunity to have a say about the quality of the service. There were meetings held for people who used the service so the provider could capture their views and listen to their suggestions and choices. We saw the minutes of the last two meetings and saw people had been given the opportunity to have their say. We saw that feedback forms had been sent to people who used the service and their relatives. The registered manager told us that once all of these had been received back there would be an analysis of the results and an action plan formulated for any improvements needed and that the results would be shared with people who used the service.

People lived in an open and inclusive service. Staff we spoke with told us they felt the service was well run and said that the registered manager and clinical manager worked with staff as a team and were approachable and supportive. Staff told us they would speak up if they had any concerns or suggestions and felt they would be listened to. They said there was not a blame culture in the service and they felt they could speak with the management team if they had made an error and would be supported.

The registered manager told us in the PIR that a member of the management team worked in the evenings and weekends to observe staff practice and be involved with the whole staff group. They said that changes

required to be made were implemented by the management team and monitored by the clinical lead nurse. We observed staff working well as a team and they communicated well with each other, appearing motivated and happy in their work. All of the staff we spoke with told us they enjoyed working in the service and one member of staff who had retired regularly visited the service as a volunteer to chat to people and partake in activities.

People could be confident that the quality of the service would be monitored. There were systems in place to monitor the quality and safety of the service. We saw that the clinical lead carried out audits of the accidents and incidents in the service to assess if any action was needed and to identify if there was any learning from the incidents. There were also weekly reports completed by the clinical lead in relation to and pressure ulcer management and monthly audits carried out in relation to medicines management and catering.

The registered provider oversaw the running of the service and ensured people were happy with the service being delivered. The provider was a regular visitor to the service and on a monthly basis they carried out an audit and completed a report of their findings. The report included speaking with people who used the service, speaking with staff and looking at a random selection of records to ensure they were being maintained appropriately. The registered manager told us the provider was supportive of the improvements needed to the environment to provide a more person centred service for people.