Pridell Care Limited

Care at Parkside

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 16 August 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Care at Parkside on 27 June 2014, at which time the service was compliant with all regulatory standards.

Care at Parkside is a residential home in Oldham providing accommodation and personal care for up to 24 older people. There were 19 people using the service at the time of our inspection.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

We found that there were sufficient numbers of staff on duty in order to meet the needs of people using the service, as well as to ensure premises were clean and well maintained. The registered manager had recently employed a domestic assistant to maintain cleanliness.

People who used the service, their relatives and a range of external professionals all expressed confidence in the ability of staff to protect people from harm. Staff we spoke with displayed an understanding of safeguarding principles and how to look out for signs of abuse.

We saw there were pre-employment checks of staff in place, including Disclosure and Barring Service checks, references and identity checks, which helped to reduce the risk of unsuitable people working with people who may be vulnerable.

Risks people faced were not always well documented and people with diabetes did not have specific care plans in place to minimise the risks they faced.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

We found all communal areas of the building to be clean, although areas such as the first floor w/c and people's bedrooms were in need of further refurbishment and redecoration.

Visiting professionals had confidence in the experience and knowledge of staff and told us they liaised well with them. There was regular liaison with GPs, chiropody, nurses and specialists to ensure people received the treatment they needed.

Staff were trained in a range of mandatory topics such as manual handling, safeguarding, fire safety, health and safety and infection control but had not been trained to meet people's specific needs, for example in dementia care.

We saw people had choices at each meal although people with diabetes did not have specific nutritional plans in place that care staff were aware of.

Group activities were planned via a weekly activities chart but we found more could be done to ensure people's individual histories, likes and preferences contributed to activity planning. The registered manager showed us work they had started to identify people's preferences and committed to continue this work and incorporate into activity planning.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The registered manager displayed a good understanding of capacity and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the Deprivation of Liberty Safeguards (DoLS).

The atmosphere at the home was welcoming, relaxed and homely. People who used the service, relatives and external stakeholders told us staff were familiar to them, caring and kind and we saw numerous instances of warm interactions.

Staff, people who used the service, relatives and external professionals we spoke with knew the registered manager and spoke positively about their approachability, flexibility and knowledge of people who used the service.

Quality assurance and auditing systems were not effective and meant concerns were not always identified, nor were opportunities to share good practice.

We found the service to be in breach of two of the regulations. You can read more about the action we told the provider to take at the back of the full version of the report.

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 always safe.

Risks to people were reduced by the actions of staff but those risks were not always clearly or accurately documented for others to be aware of.

There were safe systems in place for ordering, receiving, storing and disposing of medicines.

Pre-employment checks of staff including Disclosure and Barring Service (DBS) checks reduced the risk of unsuitable people working with vulnerable adults.

There were sufficient numbers of staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive sufficient training to enable them to effectively meet people's needs.

Staff worked well with external health and social care professionals to ensure people had good access to primary and secondary healthcare.

Staff communicated well with people who used the service.

Is the service caring?

Good

The service was caring.

People who used the service and their relatives were complimentary about the caring and patient attitudes of staff.

All external visitors and relatives we spoke with confirmed the atmosphere at the home was consistently welcoming and homely, whilst people who used the service told us they felt at home.

Care plans were written with the involvement of people who used the service and their relatives to ensure they were involved in the planning of their care.

People were treated in a respectful way and their dignity was upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people were able to pursue hobbies and interests meaningful to them and there was a weekly activities plan in place. Activity planning and the completion of work already started on person-centred care planning needed to improve.

Staff liaised proactively and regularly with healthcare professionals to ensure people's changing healthcare needs were met.

The registered manager gathered feedback regarding the service via a range of means with a view to trying to improve the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance and auditing systems, and governance of the service generally, were not effective and meant concerns were not always identified, nor could service delivery be improved through auditing.

People who used the service, their relatives, staff and external professionals we spoke with were all complimentary about the knowledge and approachability of the registered manager and staff.

We found the culture to be caring and focussed on people's needs.

Care at Parkside

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 visited the service on 16 August 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time speaking to people who used the service and observing people in the communal areas of the home. We spoke with six people who used the service and six members of staff: the registered manager, the senior carer, two carers, the cook and the domestic assistant. We also spoke with a visiting healthcare professional. Following the inspection we spoke with a further three relatives of people who used the service and two healthcare professionals.

During the inspection visit we looked at five people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the CQC. Registered providers must provide CQC with notifications about certain events, such as serious injuries to people, or deaths that occur. We spoke with professionals in local authority commissioning and safeguarding teams. No concerns were raised regarding the service by these professionals. We spoke with the public health team who had conducted an inspection of the service recently and used the concerns they raised to inform our inspection.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe at Care at Parkside. One person told us, "Yes, it's very safe here. [Registered manager's name] keeps me safe". Relatives similarly told us they felt their family members were safe. One told us, "I've never had any major issues and people are safe." Another said, "I'm not concerned or worried about [Person's] safety – they give me peace of mind."

When we spoke with external healthcare professionals they told us they also had confidence in the ability of staff to keep people safe. One said, "I've got no concerns about the service," whilst another said, "They had a person with behaviours some could find challenging. They kept in touch, came to the weekly MDT (multi-disciplinary team) meetings and were part of making sure the risks to the person were reduced."

Staff members we spoke with were aware of who to contact to make referrals to or to obtain advice from if they had concerns regarding people's safety. Staff had attended safeguarding training and were able to describe what signs of abuse they were mindful of and what to do if they had concerns. We found the registered provider had ensured staff were consistent in their knowledge of safeguarding procedures.

People who used the service and staff members told us they felt there were enough staff in the home. At the time of the visit there was a registered manager, senior carer, carer, cook and cleaner on duty. We saw from the rota that there were sufficient staff to meet people's needs during the day and overnight. We observed during the inspection that staff were able to respond to people's needs in a timely fashion. Relatives and external professionals we spoke with confirmed they had always found there to be adequate staff on duty when the visited the service. This demonstrated people were not placed at risk due to understaffing.

We saw risk assessments were in place but were not always updated or accurate. For example, one person with a history of seizures regularly left the service independently. When we asked the registered manager and a member of staff what risks the person faced when in the community and how they helped reduce these risks they told us the person had a pendant around their neck detailing instructions in the event of an emergency. They also told us the person had a mobile phone and would let them know if they were going to be later than expected. When we reviewed the person's care records we found these details were not documented in their risk assessment. Likewise, we viewed one persons' Waterlow chart. The Waterlow score is a pressure ulcer risk assessment/prevention tool used and understood by caring and nursing professionals to reduce the risk of pressure sores. We saw the scores indicated the person was at a heightened risk of pressure sores and required a specialised cushion and mattress. We saw the person did have the cushion and mattress in place but the relevant care plans or risk assessments had not been updated. This meant the risks people faced and how they were managed were not always well documented. This also meant care staff new to these people would not be aware of the risks they faced by reviewing their current care plans.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at five staff files and saw application forms had been completed and interviews held. We saw two previous employer references and a Disclosure and Barring Service (DBS) check were sought before staff commenced employment. The DBS carry out a criminal record and barring check on individuals who intend to work with children or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults. We also saw proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates.

We saw the storage, administration and disposal of medicines was in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE). We saw people's individual medicines records contained their photograph, allergy information, relevant contact numbers and medicine information.

We saw medicines were housed in a locked cabinet and a locked fridge. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits and the controlled drugs cabinet was locked and secured to the wall. We undertook a stock check of controlled drugs and found there to be no errors. Controlled drugs are drugs that are liable to misuse and therefore have more safeguards in place. We reviewed a range of people's medication administration records (MARs) and found them to contain no errors. This demonstrated people were not put at risk through the unsafe management of medicines.

We saw that the service had been inspected by the local public health department in May and that they had identified a range of concerns with regard to infection control. We saw the registered manager had implemented some of the actions the team had recommended, such as new commodes and toilet stands to replace ones that were no longer fit for purpose, along with mattress protectors where appropriate. The registered manager had ensured posters encouraging infection control awareness had been displayed and hand washing facilities and alcohol gel were readily available. We saw that general refurbishment of the home had been commenced, for example the redecorating of the entrance hall and the dining room, along with maintenance of the garden. One relative told us, "They've been sprucing the place up and they've got some new chairs in the living rooms," whilst another said, "The décor is a bit tired but the dining room is much brighter and the hall is lovely. It's always very clean."

We found communal areas including the living rooms, dining room and kitchen to be clean and free from any unpleasant odours. We noted one person's room had a strong odour of urine. The registered manager confirmed this had been a room the public health team had raised concerns about and that they intended to replace the flooring by the return date of the public health team. We saw the registered manager had, since that visit, employed a domestic assistant. We saw they kept a clear record of the cleaning they had undertaken on a daily basis and that this had had a demonstrable impact on the cleanliness of the service.

We found there were still areas to improve with regard to infection control and the standard of refurbishment required, for example one first floor toilet had a padded toilet seat that was torn, making cleaning ineffective. The lino on the floor was also worn, making cleaning ineffective. Similarly, there was a sluice sink in the laundry room which the public health team recommended be removed and replaced with more appropriate hand washing facilities. We saw this was yet to happen. The registered manager was aware of these areas and confirmed they were due to be resolved before the return date of the infection control team on 12 September 2016.

We saw Portable Appliance Testing (PAT) had been recently undertaken, whilst emergency systems such as the emergency lighting were tested regularly. We saw fire extinguishers/equipment had been serviced and periodic tests of the water were in place to protect against the risk of water-borne infections such as

legionella. We saw water temperature checks had been undertaken in all rooms to protect people against the risk of burns, although the regularity of these checks was not clearly planned. The registered manager told us they were currently completed, "As and when we can," but that they would consult relevant guidance and ensure checks were undertaken more systematically. We saw there had been an independent fire evaluation and that previous concerns raised by the local fire service had been addressed. Staff told us they had fire training and we saw fire drills had taken place. We also saw there were individualised evacuation plans in place for people who used the service. These were housed in the locked treatment at the rear of the premises. The registered manager agreed to keep up to date copies of these plans in an accessible location near the entrance to the property. This would help emergency services support people to evacuate the building in a more timely fashion.

We saw incidents and accidents were acted on and documented in a manner that allowed for easy analysis to identify any trends and patterns.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with displayed a good understanding of people's health needs and were able to describe how they supported people. External healthcare professionals we spoke with were complimentary about the knowledge and skills of staff. For example, one healthcare professional told us how they had initially struggled to speak with one person for whom English was not their first language. They described how staff were able to help them understand the person through a combination of understanding some English, body language and mannerisms. They said, "It made a real difference being able to communicate with the person and they helped me with that." They went on to say, "Staff know the person very well and that makes them want to come back."

Relatives confirmed people were supported to access primary and secondary healthcare and when we reviewed care files we found this to be the case. For example, we saw advice included from, for example, district nurses, dietitians, podiatry and Speech and Language Therapists (SALT).

We spoke with one member of staff who displayed an excellent knowledge of all people's needs and was able to talk in detail about the training they had received. Other staff we spoke with displayed a good knowledge of people's needs and the registered manager told us they were planning to implement a keyworker system to delegate more responsibility to care workers but also to ensure people received care from a more stable core of staff who knew their needs best. We saw one person had recently received additional person-centred care planning training to support this.

Management and planning of training generally required improvement. Whilst one member of staff was being supported to increase their skills we found there were necessary elements of training that had not been delivered. For example, four people who used the service were living with dementia and the Statement of Purpose lists "Dementia Care" at the top of the list of particular needs the service supports. The Statement of Purpose also describes dementia awareness as one of the mandatory training topics. The registered manager confirmed no members of staff had received dementia awareness training as part of their induction to the service. This demonstrated that care staff had not been trained to have the necessary awareness of the needs of people living with dementia. During the inspection the registered manager contacted external agencies to arrange dementia awareness training.

We saw the registered manager had not implemented 'Care Certificate' training for staff new to care. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. CQC guidance to providers is that staff new to social care should complete the Care Certificate as part of an induction, within a twelve week period. We saw this had not happened and that the induction training in place did not sufficiently equip staff with the skills necessary to perform their roles. This meant the registered provider had failed to ensure staff were well supported to achieve a level of competence in line with good practice or in a timely manner.

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

We saw individual staff supervisions and appraisals took place regularly. Supervisions are when staff have dedicated time with their manager to discuss their progress and working practices. Staff we spoke with told us they were well supported in their roles and cited shadowing other members of staff as useful for developing their skills, although we saw this shadowing was not formally planned as part of the induction process. Staff confirmed they would shadow and observe more experienced staff when they had time to do so. We saw in training records that staff had completed training the provider considered mandatory including health and safety, fire safety, moving and handling, infection control, medicines administration and safeguarding.

We saw, where people had specific goal-orientated health plans in place, these were supported. For example, one person had a goal of not losing further weight as they had a history of doing so. We saw their weight had remained stable for a number of months and had increased slightly. We saw staff had liaised with a dietitian to plan the person's dietary intake as much as was practicable. When we spoke with the dietitian they told us, "The nutrition side of things is fine – they rustle up whatever people are feeling like and they're small enough to meet individual needs. They are not averse to contacting me for advice but, at the same time, they don't overly depend on me and can support people well on their own." We saw the Malnutrition Universal Screening Tool (MUST) was used. MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw people had been given a fortified diet where they were at risk of malnutrition. The cook had a good knowledge of people' likes and dislikes and a range of people who used the service told us they enjoyed the food and that there was always a choice.

We saw each person had a range of care plans in place specific to their needs, for example communication, oral care, personal hygiene, nutrition, mobility and medication. We found one person with diabetes did not have a specific diabetes plan in place. We saw another person had a 'diabetic plan' but this merely listed the medication they were receiving and did not specify what their nutritional needs were.

The National Institute for Health and Clinical Excellence (NICE) document, 'Type 2 diabetes in adults: management,' states that people with diabetes should be supported through management of their nutritional needs. For example, the guidance states providers should, "Encourage high fibre, low glycaemic index sources of carbohydrate in the diet, such as fruit, vegetables, wholegrains and pulses; include low fat dairy products and oily fish and control the intake of foods containing saturated and trans fatty acids" (1.3.1 to 1.3.4). When we spoke with the cook we found they had a good knowledge of people's needs, including those with diabetes, and was aware of what healthier alternatives to offer people. This meant, whilst the person was getting the diet they required, this was not reflected in the care plans staff had access to and used to inform how they provided care to people.

Another external best practice guide, 'Good clinical practice guidelines for care home residents with diabetes', by Diabetes UK (January 2010) states, "All residents require an individualised nutritional plan and should have access to a registered dietitian." Whilst we saw the service had engaged well with external dietitians and nurses to ensure people received adequate external support to manage their diabetes (for example through regular chiropody visits), they did not have in place nutritional plans or tailored diabetes plans that adequately supported staff to help people manage the risk of diabetes. This meant care plans were not sufficiently detailed to give all staff clear instructions on how to support people with diabetes (for example, what hyper- and hypoglycaemic episodes looked like, what alternatives could be offered to people on an ad hoc basis if the cook was not on site).

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 considered people's capacity to make decisions and knew what they needed to do to make sure decisions were taken in people's best interests. Staff we spoke with were knowledgeable about people's level of capacity and how to support them to make decisions.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of mental capacity issues, including DoLS.

With regard to the premises and its suitability, we found the registered provider had undertaken some recent refurbishment work and had planned more. We saw there was a stair lift in place as well as a standard lift between floors, both of which were used by people using the service during the inspection to access other floors.

Good

Is the service caring?

Our findings

When we spoke with people who used the service they told us staff were patient, caring and helpful. One person who used the service told us, "They are very nice, all the girls are." Another person who used the service told us, "I like it here – [registered manager's name] is very kind. They are a good person," whilst a visiting relative said, "The staff are lovely and always make me feel welcome. I can't praise the staff highly enough. They give me peace of mind and they give [Person] everything they need."

External professionals we spoke with agreed they were welcomed whenever they visited the home and that the atmosphere was, "Homely, friendly and welcoming." One professional told us, "Staff always have time for people, and for us." Another said, "It's always nice and calm and peaceful and the staff have a nice manner."

We saw similar attitudes reflected in recent questionnaires completed by relatives. Representatives statements included, "Parkside is great. I know when I walk out the door [Person] is so well looked after I don't have to worry about a thing," and, "They look after [Person] really well." The latter comment was filled in by the friend of a person who used the service who had no relatives. We saw the service had sought this person's opinion to help understand the needs of the person using the service. Other relatives of people who used the service confirmed their views were regularly sought and considered. This demonstrated the service had regard to the views of those who knew people's needs best, encouraging advocacy and thinking about people's best interests.

The focus on a homely atmosphere was an aim set out in the Statement of Purpose and was something staff we spoke with actively sought to achieve. One staff member told us, "It should be like a home from home. It's their home, not ours – people can have breakfast whenever they want or a cuppa whenever they want – we're not rigid like that." Through speaking with a range of people who used the service, relatives, visitors and staff we saw the service had successfully delivered a homely, welcoming atmosphere in which people could feel at home.

We saw the service had recently received thank you cards. Representative comments included, "Thank you for all your care and kindness for mum and dad. We truly appreciate all you do," and, "We would like to thank you for all the loving care."

We spoke with relatives about how staff supported people and how they were able to protect people's dignity and respect their wishes. One relative told us, "They always knock – they never just go straight in." During our inspection we saw staff knocking on people's doors before entering and saw staff interacting with people in a patient manner when helping them to mobilise. This demonstrated staff acted in a manner that respected and upheld people's dignity.

Staff generally knew the people they were supporting well. They were able to tell us about people's life histories, their interests and their preferences. Staff were able to explain to us how best to communicate with people who used the service, which enabled us to ask more people who used the service about their

experiences. We also saw staff altering their communication styles to speak with a range of people, as per the information and guidance in people's care plans.

We found there had been a high degree of turnover of staff approximately eighteen months ago but, since then, a stable core of staff had been maintained and we saw people who used the service had built strong, trusting relationships with members of staff. For instance, we observed one person sharing numerous jokes with the person who was helping them to sit outside in the sun.

We saw a church service was held monthly at the home, meaning people could follow their religious beliefs in a homely setting. We asked staff how they promoted people's independence and they told us they took people out to the shops. People confirmed this to be the case. We saw one person's Motability scooter was housed at the service and that they regularly went on errands independently.

We saw rooms were personalised with people's belongings, photographs and memorabilia, although they were in need of refurbishment.

We saw people's personal sensitive information was securely stored in locked cabinets and on password-protected computer systems, in line with the confidentiality policy. We found, where people were able to consent to their care and treatment, they had done so.

Requires Improvement

Is the service responsive?

Our findings

There was a strong consensus of opinion from relatives we spoke with that the service's approach to socialisation and stimulation had improved over the past twelve months, but that there was still room for improvement. One relative told us, "The care side of things is great but in terms of socialisation they could do more." Another relative said, "They take very good care of people but sometimes there are a lot of people watching TV and not much interaction. They have tried to improve this and the girls do their best – I think they just need a bit more support." When we looked at previous questionnaires filled in by friends and family one stated, "I have always been happy with the care. Perhaps they could provide a few more activities."

We saw the service did not have an activities co-ordinator but one member of staff would provide two hours of additional support between two and four o'clock in the afternoon to support people to participate in activities, which were planned on a weekly basis. We saw these included ball games, bingo, a visiting singer, songs, darts and dominoes. We saw a visit to a local museum had been planned and there had been a party at Easter, champagne for Valentine's Day and a buffet arranged to celebrate the birthday of a person who used the service, to which family were invited.

The registered manager showed us people's 'Life Story' documents, which detailed people's life history, including their education, career, relationships, likes and dislikes. We saw five of these had been completed and the registered manager planned to complete the rest. When we spoke with one relative they confirmed how enjoyable one person had found the process of reliving their life history when helping to fill in this document. This showed the completion of the documents had a demonstrable impact on how involved people felt in their own care, and that the practice should be continued. The registered manager acknowledged these documents provided useful information regarding people's individual preferences and should be used to inform activity planning. They committed to complete life stories for all people using the service and to incorporate these stories into activity planning.

We found, despite the need for improvements in person-centred activity planning, that all operational staff, including the registered manager, had a sound understanding of people's likes, dislikes, needs and interests. Likewise, external health and social care professionals acknowledged that staff had a good knowledge of people's needs and supported them to choose on an ad hoc basis. One person who used the service told us, "I can choose what to do," and showed us the items they had bought that morning on a visit to the local shops.

With regard to people's health and wellbeing, we saw the service acted pro-actively to anticipate and meet people's changing needs. For example, one person's mobility needs were beginning to increase. We saw the registered manager had offered the person, through consultation with their relative, a larger room on the ground floor. Their relative told us, "This was done the same day – I couldn't believe how quickly they sorted it and it means [Person] no longer has to use the lift. It's really reduced the hassle and anxiety."

Relatives told us that they were contacted regularly and were involved in decisions about their relatives'

care. One relative told us, "They let me know about hospital appointments, they always ring and let me know. If [Person] asks for anything they let me know. They involve family as much as possible." Another said, "[Registered manager] is always ringing us and updating us – they let us know what's going on." Relatives were particularly positive about the manner in which staff managed the transition of people from hospital to the home, with one stating, "They were fantastic when it came to the move – [Person] had had a fall and it was new to all of us. They managed all aspects of the move and the impact."

Staff, relatives and people who used the service were knowledgeable of the complaints procedure. One relative we spoke with confirmed they had raised concerns about one particular issue regarding staff awareness of their relative's dentures and that this concern had been comprehensively dealt with by the registered manager.

We saw evidence that external help was sought regularly to meet people's health needs, such as referrals to doctors and specialists. One commissioning professional told us, "In terms of finding placements, they are always really responsive – they're happy to come out and chat through someone's needs and we can always turn up without an appointment to show a person around." One healthcare professional told us, "The communication is very good – they get in touch with me if they think there are changes." There was a consensus amongst external health and social care professionals that staff and management sought prompt help when required to meet people's health needs.

We saw resident meetings were held intermittently, whilst the registered manager had used questionnaires to routinely seek the views of people who used the service, relatives and external visitors. All the responses from the latest questionnaires in March/April 2016 were returned with positive comments regarding the approachability of the manager, levels of privacy, cleanliness and access to external healthcare services. We also saw the registered manager was trialling new ways to gather more feedback from people who used the service and visitors, such as smaller, easy read questionnaires. These methods had yet to deliver feedback but demonstrated the registered manager understood the importance of seeking the broadest perspective of views regarding the service. The registered manager agreed the regularity of residents meetings was dependent on other work pressures and that they would endeavour to ensure these meetings occurred more regularly than every six months.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had an extensive background in care and previous deputising manager experience. We observed numerous positive and supportive interactions between the registered manager and people who used the service and they consistently demonstrated a good knowledge of the needs of people who used the service. For example, we spoke with one person who smiled at the registered manager, used a pet name they had given them and talked in detail with them about what they had done that morning. Staff and relatives we spoke with confirmed the registered manager had a, "Hands on" approach to the service. One relative said, "The manager is always on hand and can't do enough to help."

Staff told us that they were supported by the registered manager, whilst relatives we spoke with expressed confidence in their ability. One member of staff told us, "I love the job and the support we get from [registered manager's name] and [registered provider's name] is out of this world." Another member of staff told us, "The manager supports us all the time. The service has changed for the better, with more rules and regulations."

This opinion was corroborated by others we spoke with. One relative told us, "It has improved a lot in the past year and that's down to the manager – if you got any questions they look into it and they make it clear we can always ask for help." Another relative said, "The manager has always been great." The registered manager, senior carer and care staff were all complimentary about the support they received from the registered provider and confirmed they had ensured resources were available to undertake recent and on going refurbishment work. For example, we saw the cook had recently reported the hot water boiler in the kitchen as being broken. We saw this had been promptly replaced with a new machine.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided and, where there was a delay, the registered provider was able to explain the delay and provide the documents in a timely fashion.

Care records were not always up to date and accurate, as discussed in specific examples in the Safe and Effective key questions. We found other instances of the documentation and governance of the service requiring improvement. For example, a recent visit by the public health team had led to a number of actions the registered manager needed to take to ensure the service was compliant with high standards of maintenance and infection control and prevention. We asked the registered manager how, when and in what order they planned to make these changes. They stated they were making the changes, "As and when time allows." They confirmed they had not put in place an action plan that allowed them to effectively meet the actions set out by the public health team. As such, we saw aspects of refurbishment such as maintenance of the outside space and redecorating the hall had taken priority over the redecoration and re-flooring of one person's room that required more immediate attention. This demonstrated that a lack of proper planning meant people had to wait longer to have their surroundings improved to meet their needs.

Similarly, auditing of processes across the service required improvement. We saw some audits were in place and had effective outcomes, such as the registered manager's walk around of the service to ensure

cleanliness standards were maintained, and the auditing of accidents to identify whether there were any common trends. Other auditing processes were however ineffective. For example, we saw there were service user room audits in place, but these had failed to identify the areas of concern noted by the external visit by the infection control team. During our inspection we identified other obvious deficits that should have been identified by a regular room audit, such as two loose headboards in need of replacement. The shortfalls identified in staff training could have been identified through effective quality assurance processes. There were no such auditing procedures in place to assure that staff had received adequate and appropriate training. The registered manager acknowledged auditing was an area the service did not do well and needed to improve.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the registered manager had forged positive links with local health and social care professionals but they acknowledged there was an opportunity to build even more community links.

We found the registered manager had successfully developed and maintained a culture that was focussed on providing people care within a setting that felt homely and familiar, but that their own oversight of the service required improvement to ensure all aspects of the service were continually reviewed and improved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not established to assess, monitor and improve the quality and safety of the services provided. Care documentation did not contain accurate and up to date information regarding people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate training as is necessary to enable them to carry out their duties.