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Argyle Park Nursing Home

Inspection report

9 Park Road
Southport
Merseyside
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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Argyle Park is a nursing home in Southport that caters for the needs of older people. It has 31 en-suite bedrooms for both male and female residents.

This inspection was carried out over two days on 17-18 May 2017 and was unannounced.

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

The service was last inspected in October 2016 and we found breaches of Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found staff had been appropriately checked before they started work in the home; the home did not always support people to provide effective outcomes for their health and welfare and there was a continued failure to provided governance [management] systems to ensure appropriate monitoring of standards in the home.

At this inspection we found the home to be meeting all of the regulatory requirements. This was an improvement from our last inspection and we have revised the quality rating for the service from 'Requires improvement' to 'Good'.

There were enough staff on duty to help ensure people's care needs were consistently met. We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We found recruitment to be well managed and thorough. This was an improvement from our last inspection.

Care records showed that people's health care needs were addressed with appropriate referral and liaison with external health care professionals when needed. Monitoring records and charts were updated so they provided for effective evaluation of care. This was an improvement from our last inspection.

There was now a clear organisational management structure in place. The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally by staff and from visiting senior managers for the provider. These were effective in managing the home; there were systems based on getting feedback from the people living at the home. This was an improvement from our last inspection.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 [MCA] were followed, in that an assessment of the person's mental capacity was made and decisions made in the person's best interest. We had some discussion, however, how this could be further improved by evidencing assessment around individual decisions; this would meet best practice and follow the principles of the MCA.

The registered manager had made appropriate referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the applications were continuing to be monitored by the registered manager.

We reviewed the way people's medication was managed. We saw there were systems in place to monitor medication so that people received their medicines safely.

Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training and this was ongoing. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified. We found the environment safe and well maintained.

Activities were organised in the home and these were appreciated by the people living at the home.

We saw written care plans were formulated and reviewed ongoing. We saw that people were involved in the care planning and regular reviews were held.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each individual person's care needs and how they communicated these needs. People living at Argyle Park told us that staff had the skills and approach needed to ensure people were receiving the right care.

People were satisfied with living in the home and told us they felt the support offered met their care needs. People we spoke with said they were consulted about their care and we saw some examples in care planning documentation which showed evidence of people's input.

We saw people's dietary needs were managed with reference to individual needs.

People told us their privacy was respected and maintained. When we observed staff interacting with people living in the home they showed a caring nature with appropriate interventions to support people.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw that a record was made of any complaints and these had been responded to.

The registered manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had been thoroughly checked when they were recruited to ensure they were suitable to work with vulnerable adults. This was an improvement form the last inspection.

We found that people had had risks to their health monitored. Assessments and care plans contained necessary detail to help ensure consistent outcomes for people's safety and wellbeing.

We found good systems in place to ensure medicines were managed safely. These were consistently monitored.

There were enough staff on duty to help ensure people's care needs were consistently met.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.

Is the service effective?

Good

The service was effective.

We found the service supported people to provide effective outcomes for their health and wellbeing. Monitoring charts were kept up to date. This was an improvement from our last inspection.

Staff told us they were supported through induction, appraisal and the home's training programme.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Requires Improvement

The service was not always caring.

There was negative feedback regarding the time taken for staff to respond to call bells.

Staff displayed reassuring and effective communication when interacting with people.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Good

The service was responsive.

Care plans were being reviewed and monitoring of people's care evidenced an individual approach to care.

There were social activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place.

There were a series of on-going audits and quality checks to ensure standards were being maintained and the culture of the home was being supported. These were effective in identifying any issues and planning the development of the home. This was an improvement from our last inspection.

The Care Quality Commission had been notified of reportable incidents in the home.

There was a system in place to get feedback from people so that

the service could be developed with respect to their needs and wishes. These included regular meetings and other formal processes to collect feedback.	

Argyle Park 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 checked whether the provider was 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 was an unannounced inspection which took place over two days on 17-18 May 2017. The inspection team consisted of two adult social care inspectors 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 the inspection we collated information we had about the service and contacted the social service contracting team to get their opinions. We also reviewed other information we held about the service.

During the visit we were able to meet and speak with 11 of the people who were staying at the home. We spoke with five visiting family members. We spoke with six of the nursing and care staff working at Argyle Park as well as the registered manager, senior managers and the provider [owner].

We looked at the care records for four of the people staying at the home as well as medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Good

Is the service safe?

Our findings

At our last inspection of Argyle Park in November 2016 we found the provider in breach of regulations because staff had not been thoroughly checked prior to employment. We found this had improved and the breach of regulation had been met.

We looked at two staff files of staff recently employed and asked the registered manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

We reviewed the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock checks and other records for people living in the home.

Nursing staff were administering medicines in the home and we both discussed with and saw evidence that they were updating their practice and management where checking competencies on a regular basis.

We observed part of a medicine round and observed the staff member administering medicines safely to people.

Medicines were stored in two locked trolleys which were kept in a locked clinical room. The temperature of the room and the medicine fridge were monitored and recorded daily and we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. Controlled medicines were stored in a separate locked cupboard in line with legislation. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

MAR charts we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had and the charts had been completed fully. We looked at a number of MARs and saw that staff had signed the MAR charts to say they had administered the medicines. We saw that for a medicine that needed to be given at a specific time, the staff ensured this was administered at the stated time. This was an important part of the person's treatment for their medical condition thus ensuring the efficacy of the medication. We saw that medicines were given safely as prescribed.

Quantities of medicines received into the home must be checked to provide an accurate stock check. We found quantities of medicines received had been checked and recorded. We checked the stock balance of a number of medicines (including a controlled medicine) and they were accurate.

We saw evidence of PRN (as required) protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. Guidance regarding administration of people's medicines recorded within people's care plans; this included the administration of PRN medicines. When reviewing a number of MARs we saw that some people were prescribed a painkiller such as, Paracetamol.

This was to be given 'morn', 'noon', 'tea' and 'bed'. We discussed with the registered manager the need to record the actual time the medicines was given to ensure accurate records were kept when administered. This ensures the correct length of time is left between the doses.

Nutritional supplements were given as prescribed for people who had a poor intake and the application of topical preparations (creams) were recorded on the MAR charts and cream charts which were up to date and signed by care staff who had applied the cream.

Some of the people living at the home where prescribed 'thickening' powder to thicken their drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. The number of scoops of thickening powder required to ensure the correct consistency of fluid for each person was recorded on people's care fluid chart. This instruction was in accordance with people's nutritional assessment and advice from the speech and language therapy team (SALT).

The registered manager informed us that no one at this time was receiving their medicines covertly. Covert administration for medicines means giving people medicines without the person's consent or knowledge in their 'best interest'). The registered manager was aware of the procedures that needed to be followed if medicines were required to be administered this way.

We spoke with people about whether they felt safe living at the home. Everybody said they felt safe at the home and that nobody made them feel unsafe or bullied in any way. Some responses included: "Yes, its fine here – everything's fine", "Yes; nobody bothers me", "They're all very nice here" and "Well, I have my walking frame there and I feel very safe using that. I used to fall – at home – and now I'm ever so safe." The lounge/dining areas were spacious enough to allow people to move unhindered, with or without support.

We saw one person being transferred from chair to wheelchair using a hoist. This was done carefully and safely, with carers taking time to check and readjust the person's position as necessary; the person seemed at ease and comfortable throughout.

Lifting/support equipment was evident in bathrooms. There was fire equipment in all areas and we saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home. This helps to ensure effective evacuation in case of an emergency. We saw the PEEP's plans kept in the office needed to be updated with the latest admission and this was completed on the inspection. The registered manager said they would introduce a check for this on one of the audit tools.

We found arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We saw comprehensive records of all of the routine environmental checks made in the home.

Maintenance / safety certificates we saw were up to date. Overall there was good attention to ensuring safety in the home and on-going maintenance.

We asked people if they thought there were enough staff on duty at all times to support everyone appropriately. People were satisfied with staffing levels generally and felt these had improved over the last year and were more consistent; one person commented "There haven't been [enough staff] but it's getting better." Another person said, "Yes, there are enough staff I think." We spoke with one relative visiting who told us, "The staffing situation has settled down a lot. They are more consistent now which means more consistent care. I would say this is main improvement."

The registered manager advised us they had worked hard to ensure safe staffing levels. The home had recently increased staffing on a late shift by one carer to provide timelier personal care over this period.

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was now more stable. One staff told us, "Staffing has improved and is more consistent. It's improved in the afternoon which is a great help."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available. Since the last inspection the registered manager had identified some safeguarding issues and had reported these effectively with good liaison with the safeguarding authorities.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails.

When we looked round the home we found it to be clean. There were no unpleasant odours. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. All of the people living at the home and visitors we spoke with told us the home was always maintained in a clean and hygienic state. One relative commented, "Yes [home is clean] and [person] is always presented very well, especially when you take into account the tremendous dependency of the people here; so many need a lot of help."

Good

Is the service effective?

Our findings

At our last inspection in November 2016 We found the service in breach of regulations because they did not support people to provide effective outcomes for their health and wellbeing. On this inspection we found improvements had been made and the breach had been met.

We reviewed the care of three people in depth by tracking their care through observation and care records. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. We looked at how medical conditions were recorded and how staff followed treatment plans to ensure people's health and welfare. This included the care and treatment plan for a person who had a tube for enteral feeding. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. Staff were providing care which met the person's nutritional needs and also the care required for the PEG site/line. Care monitoring charts were in place to record the provision of the enteral feeds and also the care of the PEG site/line. Staff were following documentation to support the care of the PEG site and we discussed with the registered manager the need to also record this on the person's plan of care.

Another person we reviewed had health care needs around difficulty swallowing and nutrition, mental health care needs and risks associated with skin integrity. We found all of these were being monitored effectively and there had been liaison with supporting health care professionals including the Speech and Language Therapist [SALT] and the mental health services. We saw the person had necessary assessments in place to monitor risk of skin breakdown and was supported on a specialised mattress; these factors helped to reduce the risk of complications and maintained the person's health. We saw that, despite measures in place there had been a small breakdown of the persons skin; this had initiated and referral to the tissue viability nurse for further assessment and support.

In all of the people we reviewed there was good attention to updating monitoring records such as fluid charts and repositioning charts [we suggested fluid charts are totalled daily for easier reference]. Poor attention to these had been a feature of previous inspection. Good maintenance of these records helped to provide for effective evaluation of the care provided.

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. One person told us, "Yes, I think most of them do and they've had the training. We get young ones sometimes and see them being trained by the more experienced staff."

We were told the provider had set up an academy with training managers to oversee the training requirements for staff employed at the Dovehaven homes. The Dovehaven academy set out short term and long term objectives for the staff in respect of assessing staff's training needs for subjects they consider mandatory and staff were enrolled on formal qualifications in care. This is to ensure the staff have the skills, knowledge and expertise to meet people's individual needs and to further their learning and development.

We looked at the induction process for new staff employed at the home. The registered manager explained the induction process which included a standard checklist of information carried out over the first few days of employment, a handbook for new staff, some shadowing of experienced staff and attendance at mandatory training such as moving and handling, safeguarding of vulnerable adults, fire safety and general health and safety. Staff we spoke with confirmed these arrangements for induction.

We were told staff were also enrolled on the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. The standards cover areas such as, infection prevention and control, safeguarding adults, working in a person centred way and duty of care. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within twelve weeks of starting employment. The academy where monitoring this and had recently developed a three day induction training package which incorporated elements of the Care certificate.

We discussed with the registered manager other formal qualifications in care which staff had achieved or were enrolled on. We saw that staff were undertaking accredited qualification made up of units such as, NVQ (National Vocational Qualification) or Diploma under the QCF [Qualifications and Credit Framework). With regards to formal qualifications in care the manager told us 16 out of 18 care staff [88%] had obtained a NVQ in care. This was confirmed by records we saw.

The 'training matrix' we saw evidenced courses undertaken in respect of subjects such as safeguarding adults, moving and handling, infection control, food hygiene, Mental Capacity Act 2005 [MCA], Deprivation of Liberty Safeguards and fire safety, as a way of enhancing staff knowledge.

Staff support included supervision meetings conducted by the manager with individual staff. Staff we spoke with felt they were fully supported by the registered manager.

We looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had applied for a number of people to be supported on a Deprivation of Liberty Safeguards (DoLS) authorisation. The applications were being monitored by the registered manager of the home. We saw that if people were on a DoLS authorisation there was a supporting care plan to reference this.

The staff and registered manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. For example we saw assessments for people making the decision to accept '24 hour care' at Argyle Park. We saw supporting assessments and documentation which supported good practice in this area and made use of mental capacity assessments with good supporting care plans and liaison with social care professionals and peoples relatives when appropriate. The staff showed an understanding that peoples mental capacity could fluctuate depending on circumstance and the decision in question.

Other examples included care files showing were people had consented to their plan of care. We saw

examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or the decision had been made in the person's best interest after consultation with advocates [family members].

We had further discussion with senior managers and the registered manager regarding further evidencing assessments around mental capacity. For example we saw bets interest decisions being made for some restrictive practices such as the use of bedrails which would benefit for the use of the two stage mental capacity assessment tool available to staff.

People were generally positive about the food and the choices offered. People commented, "There's a choice for every meal. The [staff] come every morning and ask. We have drinks in the morning and a drink and snack every afternoon", "On the whole it's not bad at all. There's enough choice, yes. If we complained, they'd [the home] listen", "The food is excellent, and no problem with choice" and "It's lovely [person went on to describe what they'd had for lunch]. You get a drink every morning, and every afternoon there's a drink and a snack."

We saw a number of people being supported to eat and drink, both in the lounge and in their own rooms. Staff were patient and chatty with the people they were supporting, so there was no sense of dependency generated. Some people had their drinks served in adapted cups, so that they could drink safely and independently. Some people had their food served pre-cut or mashed, to meet eating needs. Drinks were served between meals, both morning and afternoon; a choice of hot and cold drinks was offered, together with biscuits in the morning and other snacks in the afternoon. We saw bowls of fruit on the two dining tables in the lounge.

Only one person sat at a dining tablThe service was safe.

Staff had been thoroughly checked when they were recruited to ensure they were suitable to work with vulnerable adults. This was an improvement form the last inspection.

We found that people had had risks to their health monitored. Assessments and care plans contained necessary detail to help ensure consistent outcomes for people's safety and wellbeing.

We found good systems in place to ensure medicines were managed safely. These were consistently monitored.

There were enough staff on duty to help ensure people's care needs were consistently met.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.
And for lunch; most people in the lounge sat in armchairs with side tables used for their food. Although this was said by one carer to be individual preference, it did not support social interaction or maintenance of eating skills.

Requires Improvement

Is the service caring?

Our findings

Staff were consistently kind and friendly in their support of people at Argyle Park and relationships appeared to be good between staff and people living there.

People responded positivity when we asked about care in general and staff attitude but we received negative comments when we asked specifically about staff responding when people required direct assistance; this was in relation to staff responding to a call bell (which people activated when they needed assistance); negative responses here were a theme. People said, "You can wait 15 to 30 minutes [in own room] in the day. At night it's pretty quick, usually", "Personally I don't think there are [enough staff]; people have to wait for a while before someone comes", "People wanting the loo – they [staff] say they'll be back in a minute but it's more like an hour sometimes – they seem to forget. There was a bell in the lounge for a while but people misused it, apparently. In your room, you can wait anything from zero minutes to half an hour."

Staff told us they answered calls bells as soon as they could though at different times of the day the response time could be longer. For example, serving and supporting people with their meals or providing personal care for someone else. Many people required two staff to carry out care [using the hoist for example] and staff had to wait for a second staff to be free. A staff member said, "It's difficult at certain times, when we are serving tea evening meal] for example and somebody needs the loo. Mostly though the wait is no longer than ten minutes."

This was reinforced by one person living at the home who also identified this as a key time when staff could not respond.

During the inspection we observed staff supporting people in accordance with their requests and needs. It was however difficult to monitor the length of time calls were answered. The buzzer sounded throughout the home and there was a display unit on each floor showing the room number in which the buzzer has been activated. We observed several staff members sitting with people at different times of the day or popping into rooms to check if people were comfortable and needed a drink.

We spoke with the registered manager and provider regarding the feedback from people and it was agreed that an audit would be carried out look at staff response time to calls for assistance and part of this audit would include a review of the current staffing levels.

We recommend the provider reviews how staff respond to people's needs taking into account people's dependencies and the current staffing levels.

When we asked people if they were treated with kindness and compassion and whether their privacy was respected, responses were all positive. We saw and heard staff knocking on people's doors before entering, or saying hello/calling the person's name when their door was open, before going in. We observed a carer who, whilst supporting a person in moving from a wheelchair to an armchair, ensured that the person's legs

were covered with a blanket as much as possible and standing in the way of other people's view when this became difficult. One person commented, "Yes, they [staff] are kind; yes they do [treat people with respect]. You have good relationships with them here, I think; I think they know me well."

When we spoke with staff they came across as caring and interested in their work. The staff we spoke with were able to talk about people as individuals and knew their preferred choices regarding routine. Staff told us that the home was very busy in the morning but staff did get time to engage with people in the afternoon.

Care plans we viewed contained evidence of people and /or their families being involved in the care planning process; this was evident through signed consent forms and records of discussion with people and families.

We saw that people had access to advocacy support if needed. The local advocacy service was advertised in the home.

Good

Is the service responsive?

Our findings

We asked people how staff knew what they liked/disliked, or about their interests, and if they could choose what they wanted to do, such as activities, life choices, people they want to be with. People told us they were able to make choices. They said they could choose how and where they wished to spend their day, what meals they would like served and what time to get up and retire at night [in general]. A number of people chose to spend time in the lounge whilst others preferred to spend time in their own room.

Visitors reported they had a choice to visit when wished and said there were no restrictions on this in terms of timing. All said they could visit in shared or private rooms, as they and the person being visited wished. This helped ensure people did not become socially isolated.

We asked about people's involvement in their care and how this was planned. Two people could remember seeing their care plan. Three people said they thought that a family member or friend was responsible for this. One person commented, "I haven't seen my care plan, no; I have two [relatives] who know about everything whilst another said, "Yes, I've seen and been involved in my care plan." a relative commented that they had been involved in a care review a short while ago and was fully aware of their relatives care plan.

A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care.

Care plans were specific to the individual and there was reference to people's life history to get to know people's social care needs in more detail. These records, along with staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs.

We asked what sorts of things the home provided to keep people interested, active or involved.
Most people said they were aware of a number of activities provided by the home although not all chose to take part in these. One person showed me the newsletter they were currently writing, which they had asked permission to do as a regular event; other examples of these were visible in the lounge. Other people told us; "There are exercises and there are trips once a fortnight on a little coach; we haven't been lately though. We go to places like farms or zoos [unsure] and have a look at the animals; I like that", " We do have the odd singer coming in too", "We have cards, games, we throw a ball around; the hairdresser comes very week. We get trips too, sometimes" and "Yes [there are activities provided], and I try to instigate things like card games too."

We saw singer at the home celebrating service user's birthday and this was very much enjoyed in the lounge. The activities organiser was also present and was also playing music. The person was made to feel very special by the staff. It was a lovely relaxed atmosphere.

The social activities organiser attended the home two mornings a week. they were very enthusiastic about their role and said how much they enjoyed the job. They discussed how people are encouraged to join in and how therapeutic 'dog therapy' was as people engaged more when pets were brought in. we saw this with two visitors who brought pets into the home.

People had access to a complaints procedure and this was available to people within the home advertised in the entrance foyer. The registered manager said they would also advertise this in the main lounge area. The complaints process was also included in the 'service user guide' available to people. One person showed some awareness of a complaints policy/procedure. Three people, including this person, said they would speak to management if they had any issues or concerns.

A system was in place to record and monitor complaints and those we viewed had been responded to appropriately in line with the provider's policy.

Good

Is the service well-led?

Our findings

At our last inspection of Argyle Park in November 2016 we found the provider in breach of regulations because there had been a lack of management structure and governance processes which had resulted in continued failure to meet regulatory requires.

On this inspection we found improvements had been made and the breach of regulation had been met.

There was now a clear management structure for the service from the providers, senior managers and registered manager. There was also a training officer for the provider who organised the training 'academy' which now supported on-going training in the organisation. The provider and senior managers were present at varying points during the inspection. The providers visited the home regularly and we saw they were integral to the monitoring and oversight of the home together with the senior 'regional' manager. The registered manager commented that this structure had been very supportive of their role with regular management supervision and meetings held with other managers in the organisation which the provider also attended. Communication had improved.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. Internally, we saw audits carried out for medication safety, care planning and routine checks for health and safety regarding the environment and infection control; some of these on a daily basis and others weekly or monthly. The registered manager completed a weekly return to the regional manager which updated key indicators and was also review by the provider.

Senior managers had also conducted audits including infection control and health and safety six monthly audits as well as more encompassing audit based on reviewing safety, care, responsiveness, effectiveness and 'well led' in terms of management arrangements [SCREW audit]. We were advised that once the six monthly audits were completed they are forwarded to the regional managers who review with the home manager and address the shortfalls identified in the action plan and attach time scales. We the most recent example of this carried out in March 2017. We saw that areas of lower scoring had been included in an action plan which had subsequently been updated. A more recent [May 2017] health and safety inspection had raised issues around training for staff in first aid which had been addressed.

A senior manager advised us, "The regional managers will oversee the audits carried out by the home manager – we need to show these at our provider meetings every month."

In addition to the internal organisational auditing system the home welcomed external scrutiny. We saw a recent clinical audit by the local Clinical Commissioning Group [CCG] which had been completed in two parts and showed improvement from September 2016 to April 2017 when the home had been re-audited and had scored 93% [from 63% in September 2016].

We found the registered manager exposed a positive ethos of care in the home. the feedback from people we spoke with and their relatives was generally positive in that most said the home had improved and more

settled since the register manager had been appointed. One relative commented, "It's improved a lot since the manager has arrived – it's a different place."

The registered manager told us they felt supported by the providers development of the governance arrangements and support which had helped them to develop standards in the home. The registered manager was open and we saw they could reflect positively on the feedback we gave as we went through the inspection.

The service had also developed good systems for getting feedback from people living at the home and their relatives as well as staff. We saw a series of surveys and meetings aimed at seeking feedback about the home. For example a recent food survey had collected positive comments regarding the meal time provision. The last relatives / resident survey carried out as recently as may 2017 also recorded positive responses.

The registered manager had been keen to elicit the views of professionals who visited the home; we saw recent comments from a health care professional, who said 'Staff are always visible and responsive. Staff are well informed regarding the patient's condition'.

November 2016 again gave positive feedback and a good overall satisfaction rating regarding the home generally. We saw that issues picked up had been addressed by the registered manager.

The manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

From April 2015 it is a legal requirement for providers to display their CQC (Care Quality Commission) rating. 'The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided'. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for the Argyle Park was displayed for people to see.