Parkcare Homes Limited

Preston Private

Inspection report

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Preston
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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This unannounced inspection took place on 20 July 2015. Preston Private provides accommodation for up to 106 people who require nursing or personal care. At the time of our visit there were 99 people who lived there. The home provides care and support for people with dementia or physical disabilities.

Preston Private is a purpose built care home set in its own grounds and located in a residential area of Fulwood Preston. All bedrooms are ensuite and located on the ground floor. The home is divided into four distinct areas, known as units. Two units provide nursing care, one unit provides personal care and there is one unit which provides care for people with dementia.

We noted that changes in the way the service was managed and the way in which people's care needs were assessed and planned for, which had brought about improvements to the service. We also noted that the home's medication policy was now consistently followed throughout the home, staff induction training was now taking place in a consistent manner, complaints were

Summary of findings

now dealt with robustly and the home's management team were providing good leadership. However, at this inspection, different issues where identified, which again meant that the service needed to continue to improve.

The service has a registered manager, and has managed the home for 13 months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's individual needs were not fully met and enhanced by the adaptation, design and decoration of the home, especially the dementia care unit. This area of the home was not particularly `dementia friendly`. Appropriate signage and picture menus for those people in the more advanced stages of dementia were not available, and would have proved beneficial and reflected a more person centred approach to providing care. This was a breach Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although food and hydration was provided, people's preferences regarding food and mealtimes were not always fully considered, and further work was needed to ensure people's needs were assessed fully and met. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback from people at the home, and our observations showed that there were very limited activities provided. The service provider did not ensure that people's needs were in a person centred manner, and this needed to include ensuring that people's social and cultural needs were met. This was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit, we identified a number of key areas were improvement was required, and this had not been identified by the service provider's quality assurance systems. The service provided must have an effective system in place to ensure that all the systems operated in the home can be robustly assessed and monitored all the relevant Regulations that apply to the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were found to be knowledgeable and the training records showed that staff had received appropriate training in the area of safeguarding. The people we spoke with told us they felt safe living at this home. We found information within people's care records to show that the risks associated with their care and support needs were managed properly. Our observations found that on the whole, there were sufficient numbers of suitable staff available to keep people safe and meet their needs.

We found evidence to show that medicines were properly managed. The premises and equipment within the home were properly managed, and we show records to show that appropriate safety measures and periodic checks were made on equipment to ensure it was safe to use.

The training plan showed that staff received core training and regular updates to refresh their knowledge, for example in moving and handling and first aid. All new staff members completed a fully recorded induction programme. Staff told us they felt well supported by the registered manager, deputy manager and qualified nurses and that supervisions took place, so that they could discuss their development needs.

We found written records to show that considerations had been made to assess and plan for people's needs in relation to mental capacity. The registered manager and staff had a good understanding of MCA and DoLS. The home had a suitable complaints policy and procedure that was publicised in its Statement of Purpose and the documentation was provided to new people entering the home.

You can see the action we have taken to ensure that the service provider makes improvements to the service at the end of this report.

Summary of findings

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.

During our visit we saw staffing levels were sufficient to provide a good level of care. People we spoke with confirmed this.

Safeguards were in place to ensure people were not at risk from abuse or discrimination.

People were protected against the risks associated with the unsafe use of medicines.

Is the service effective?

Requires improvement

The service was not always effective.

Although food and hydration was provided, people's preferences regarding food and mealtimes were not always fully considered, and further work was needed to ensure people's needs were assessed fully and met.

The service provider did not ensure that people's needs are met in a person centred manner, and this included ensuring that the building and environment was person centred and adapted to meet people's assessed needs, specifically those with dementia care needs.

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We spoke with staff to check their understanding of MCA and DoLS. Care staff's knowledge of MCA and DoLS was good.

We observed throughout the day that people's consent was sought by staff at all times, either before entering people's rooms, when assisting people to mobilise or when assisting people with their medication. We discussed dignity, privacy and consent with staff who were all knowledgeable in these areas. Staff were able to give us practical examples of how issues such as consent were dealt with on a day to day basis.

Is the service caring?

Requires improvement

The service was not always caring.

Although the staff were seen to be kind and caring, one situation could have been handled in a more positive manner, and we recommend that the service provider reconsiders the current guidance and best practice on ensuring that people are treated with dignity and respect at all times and take action to update people's practice accordingly.

Summary of findings

Feedback from people about the attitude and nature of staff was positive. One person said, “They’re pretty good, they give me time to do things, and are patient.” “The staff did a good job, they are very helpful.” People’s bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom.

People explained that that been given the opportunity to have input into their relative’s care plan, and had been consulted about changes to the care that had been provided.

Staff confirmed they had received end of life care training, and we saw evidence of this training taking place.

Is the service responsive?

Requires improvement

The service was not always responsive.

Although activities were provided, these were seen to be limited, and we recommend that the service provider reconsiders the current guidance and best practice on ensuring that people’s social and cultural needs are met and take action to update practice within the home accordingly.

People we spoke with and their relatives told us they knew how to raise issues or make complaints. We saw that the home had a complaints procedure and that it was made available to people, this was confirmed when speaking with people and their relatives.

We saw that people’s care plans were written in a clear, concise way and were person centred. People’s healthcare needs were carefully monitored and discussed with the person as part of the care planning process. We saw that timely referrals had been made to other professionals as appropriate such as GP’s, dieticians and district nurses.

Is the service well-led?

Requires improvement

The service was not always well-led.

We identified a number of key areas were improvement was required, and this had not been identified by the service provider’s quality assurance systems. The service provided did not have an effective system in place to ensure that all the systems operated in the home can be robustly assessed and monitored all the relevant Regulations that apply to the home.

People living and working at the home or their relatives spoke positively about the manager and relatives told us they could approach managers or staff with any issues they had.

Records were held securely and confidentially

Preston Private

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.

The inspection team consisted of the lead adult social care inspector, a second inspector, a specialist advisor, who was a district nurse, and an expert by experience who had personal experience of caring for older people, and who had previously worked as a district nurse.

Before the inspection, we reviewed information we held about the home, such as statutory notifications, safeguarding information, previous inspections reports and any comments and concerns. This guided us to what areas we would focus on as part of our inspection.

We spoke with a range of people about the service. They included nineteen people who lived at the home, ten visiting family members and twelve staff members. We spoke with the registered manager and the area manager for the service, nine members of staff and an administrative worker. We spent time observing people's level of engagement and interaction, and the quality and frequency of the staff interactions.

We spent time looking at records, which included twelve people's care records, the training and recruitment records for four members of staff and records relating to the management of the home.

Good

Is the service safe?

Our findings

The people we spoke with told us they felt safe living at this home. They told us that they trusted the staff. One person said, "The staff are nice and I feel safe." Another person told us, "I feel safe and don't have any worries." A person's relative said, "I don't have any concerns about safety and think all the staff are competent. I have recently been away on holiday and I had no worries."

We spoke to staff about how they, and the service provider, safeguarded people from harm and abuse. Staff were found to be knowledgeable and the training records showed that staff had received appropriate training in this area. All of the staff we spoke with had an understanding about safeguarding people from abuse. Staff told us that they received regular updates to their training about this. During discussions, staff were able to demonstrate that they knew how to recognise the signs of possible abuse and would report it appropriately. One staff member said, "Safeguarding is part of our induction training when we first start, and we do get regular training on safety issues, risk assessments and how to report concerns." Another staff member told us, "I know all about whistleblowing and when to use it and if I had to, I would, if I thought someone was getting harmed". Staff told us they felt confident about raising any concerns with the management team. They knew there was a safeguarding policy at the home and could tell us what was in it.

We found information within people's care records to show that the risks associated with their care and support needs were managed properly. Assessments of people's needs took into consideration the risks to which people were exposed in respect of mobility and falls, moving and handling, pressure area care and nutrition. However, we saw that for one person the assessment in respect of the risk of them developing a pressure ulcer had been incorrectly calculated. This meant that they were potentially at risk of not receiving the care they needed to ensure their safety, and the Registered Manager explained that she would deal with the issue on the day of the visit. The assessment was revised to ensure it reflected the person's current needs and risks.

Our observations found that on the whole, there were sufficient numbers of suitable staff available to keep people safe and meet their needs. Information held within the rotas confirmed this. We spoke with people living at the home about the staffing levels. One person said, "I think there are enough staff around, if you need anything or any help you just ask". Another person told us, "They come to you when they can." They told us that they had to wait, 'quite a long time' on occasions but they understood that this was because staff were trying to respond to everyone. They said that the longest waits were usually first thing in the morning. This was discussed with the Registered Manager who stated that she would look into the issues, and talk to people in the home.

One relative whose family member lived on the dementia unit told us, "There are always staff about. It seems there are as many staff as there are patients." Staff told us that they felt there were adequate numbers of them on duty to meet people's needs in a timely way. They said that any shortfalls in the staffing numbers were usually covered within the staff team. However, several staff reported working long hours and often daily 12 hour shifts, which they found tiring. On the day of our visit, the night shift was not covered, and so the deputy manager had gone early in order to get some rest because she was asked to work the night shift.

The systems relating to the safe recruitment of staff were found to be appropriate. Safe and effective procedures were followed for all staff, including temporary and agency staff, students and volunteers. Information held with the personnel records showed that the service had assessed the character of applicants during an interview process, and had undertaken appropriate safety and employment checks to ensure people were either clear to work in care, or unsuitable for employment. The Registered Manager explained that the application and interview process was in place to check that potential staff had the right skills and qualifications needed to do the job. Once people were employed to work at the home, we saw that the service provider had a robust procedure in place if they needed to take disciplinary action against a staff member for whatever reason. This included referrals onto other relevant agencies and professional bodies such as the Nursing and Midwifery Council or the Disclosure and Barring Service.

We found evidence to show that medicines were properly managed. We saw people being offered their medicines and asked if they would like to take them at that time. One person told us, "I let the staff look after my medicines otherwise I would forget." We looked at the arrangements

Good

Is the service safe?

for the ordering, storing, recording and administering of medicines and found that these were safe. We saw that the records of stock held corresponded to the medicines in cupboards and trolleys. Oral medicines were stored safely. We checked the systems in place in respect of controlled drugs and found these were safe. We saw that medicines were checked each day to ensure that there were no errors. We observed a qualified nurse administer medicines to people receiving nursing care and a senior care staff to those people receiving residential care. Both staff followed safe procedures for the administration of medicines. All staff received training from an outside provider and their competence was assessed before they were able to administer medicines unsupervised. All staff handling medicines received regular refresher training on an annual basis.

The premises and equipment within the home were properly managed, and we were shown records that displayed appropriate safety measures and periodic checks were made on equipment to ensure it was safe to use. People were protected by appropriate prevention of, and control of infection measures. Bedrooms, lounges, bathrooms and toilets were seen to be clean, and staff were seen to observe hand washing techniques prior to, and after personal care was given.

Requires improvement

Is the service effective?

Our findings

We checked to see that people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities.

We found documentary evidence to show that ongoing assessment, planning and monitoring of nutritional and hydration needs and intake took place, and daily records were kept. We noted that if people were identified as being at risk of poor nutrition or hydration, then specific care plans were put together to meet this need, and great attention paid to people's food and fluid intake. .

We spoke to people about the food at the home, one person said, "I like the food here, you get plenty and we had a couple of choices today". Another said, "I normally stay in my room for my meals, but you can have your meal in the dining room if you want to: it's up to you." One person needed to use the bathroom and we observed a staff member supporting the person with their personal care requirements. One person required a `pureed` meal and we saw each item of food had been individually pureed. There was a choice of mash potato and chicken or sausage and two vegetable's.

Although food and hydration was provided, people's preferences regarding food and mealtimes were not always fully considered, and further work was needed to ensure people's needs were assessed fully and met.One person said, " I would prefer to eat my meal here, in my room, on my knee, but I'm always asked to go to the dining room. The food is bland because they don't season it". One person said, "I don't like the way they bring me a meal, I don't get a choice. They don't bring any menus round to choose from." We fed this information back to the registered manager, who agreed to discuss mealtimes with people at the home, in order to ensure their preferences and needs were being met. Two people at the home said that the portions were sometimes not particularly big, and said when they asked for more food, they were sometimes, but not always told that there wasn't any more available.During lunch, we noted that one person only had the use of one arm and the staff were seen to cut up the chicken on their plate, to make it easier for them to eat. However there wasn't a plate guard on the plate, and as a result, this person had a problem eating their food. We asked for a plate guard to be provided but the staff said there weren't any available. We noted that one person did not eat their meal and we did not see any alternative being offered which meant the person had no lunch. Staff were informed of this situation, and the person was given a meal later in the afternoon.When afternoon tea was served we didn't see any biscuits, cake or fruit on the trolley, although this was on the menu. The housekeeper told us that a fruit platter was served in the afternoon; however we didn't see any fresh fruit served during the time we were in the home. We explained to the registered manager that mealtimes can, and should be a highlight of the day, and she agreed that further work needed to be undertaken with the staff to ensure that this was always the case.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the building to be large and spacious, however, its design and layout was not entirely appropriate to the meet the needs of the people living there. Reasonable steps had been taken to ensure that premises were accessible. The premises and grounds were well maintained and potential risks to people's safety had been identified and managed through a risk assessment process. People's individual needs were not fully met and enhanced by the adaptation, design and decoration of the home. The home was not particularly `dementia friendly`. Appropriate signage and picture menus for those people in the more advanced stages of dementia would have proved beneficial and reflected a more person centred approach to providing care. The provider may benefit from looking at NICE and Alzheimer Society guidelines related to dementia care environments. There was an absence of warm tones used on walls; very few clear signs (using pictures and words) to enable residents to move around confidently; a lack of memory boxes for people to fill with personal items for reminiscence and to help navigate them to their room and very few fixtures and fittings that created links to the past. We discussed these points with the registered manager who said that she would explore the options available to her to try and make the unit more dementia friendly.

This was a breach Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must ensure that people's needs are met in a person centred manner, and this includes ensuring the building and environment is person centred and adapted to meet those assessed needs.

Requires improvement

Is the service effective?

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The MCA is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. DoLS are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken. We found that action had been taken by the service to assess people's capacity to make decisions. We found written records to show that considerations had been made to assess and plan for people's needs in relation to mental capacity. The registered manager and the staff had a good understanding of MCA and DoLS.

We looked at two care plans for people who were subject to DoLS. We saw all the required paperwork had been completed. However, within one file, the start date for the DoLS was May 2015 and the best interest meeting and mental capacity assessment took place during June 2015. We spoke to the registered manager regarding this, and she believed there had been a mix up of the way the dates had been recorded. She agreed to ensure this was rectified, and we noted that appropriate changes were later made to the documentation once a discussion with staff had taken place to clarify the situation.

Within another application, all the criteria were met and the required assessments had been conducted. The application had been authorised by the local authority and was present within the records we saw. An application for DoLS had been submitted for all service users at the home following the Cheshire West ruling relating to `not being free to leave and being under constant supervision and control`. Staff members we spoke with were aware of the use and reason for DoLS. All staff had undergone mental capacity and dementia awareness training. Two staff members told us if they noticed a change in a person`s behaviour or capacity to make decisions for themselves, they would inform senior staff and the manager immediately.

The Registered Manager explained that many of the people living at the home had significant healthcare needs. We found information to show that some people had been assessed as being at risk of losing weight and of dehydration. Systems were found to be in place to monitor and manage these risks, and record keeping was both accurate and up to date.

The training plan showed that staff received core training and regular updates to refresh their knowledge, for example in moving and handling and first aid. All new staff members completed a fully recorded induction programme. We saw that staff also received training relevant to their role, for example medication, dignity in care and end of life care. Staff members also had the opportunity to gain a national qualification.

Staff told us they felt well supported by the registered manager, deputy manager and qualified nurses and that supervisions took place, so that they could discuss their development needs. The registered manager showed us a supervision record that set out when and how frequently staff would receive either supervision or an annual appraisal. This was seen to be in good order, as were the individual supervision notes.

Requires improvement

Is the service caring?

Our findings

Feedback from people about the attitude and nature of staff was positive. One person said, “They’re pretty good, they give me time to do things, and are patient.” “The staff did a good job, they are very helpful.” Staff showed they cared for people by attending to their feelings. People’s bedrooms were personalised and contained photographs, pictures, ornaments and other items each person wanted in their bedroom. This showed that people had been involved in establishing their own personal space within the home.

We looked at the ways in which people were supported to understand the choices they had that were related to their care and support, so that they could make their own decisions. We spoke to four people at the home who said they were comfortable when expressing decisions about their care. One person said that they could approach the staff or manager to discuss issues such as the food, clothing and medication. A number of people were unable to express their views about their involvement in decision making, so we spoke to a number of relatives and visitors about this. One told us that they felt they could influence the care and support their relative received, and explained that they had been involved in significant decisions about their relative’s healthcare. Another explained that that been given the opportunity to have input into their relative’s care plan, and had been consulted about changes to the care that had been provided. We found documentary evidence to support this in the care plans and risk assessments.

We observed care workers knocked on people’s doors before entering rooms and staff took time to talk with people or provide activities. People were treated with dignity and respect by staff and they were supported in a caring way. However, we went to talk to a person in their bedroom, and found the door was ajar and we could hear voices in the room. When we knocked, a carer came to the door and said, “we are changing his pad.” This could have been dealt with a little more sensitively.

Care workers used people’s preferred names and we saw warmth and affection being shown to people. People recognised care workers and responded to them with smiles which showed they felt comfortable with them. Tasks or activities were seen not to be rushed and the staff were seen to work at people’s own pace.

Staff confirmed they had received end of life care training. A member of staff explained, “The end of life programme allows us to have sensitive discussions as end of life approaches. We make detailed records on the co-ordination of care; care in the last days of life and also care for the bereaved.” One nurse said, "We arrange for staff to be with people, until their family arrive. No one is left alone. If we need an extra member of staff we can do this.” People were involved in decisions about their end of life care. For example one person had a ‘do not attempt cardio pulmonary resuscitation’ (DNACPR) order document in place and an advanced care plan (a plan of their wishes at the end of life). We saw the person and their family were involved in this decision.

We recommend that the service provider considers guidance and best practice, such as that produced by the Social Care Institute for Excellence, on ensuring that people are treated with dignity and respect at all times, and take action to update people’s practice accordingly.

Requires improvement

Is the service responsive?

Our findings

Information held within the care plans showed that people had been actively involved in their assessment of need to a lesser or greater degree, depending on their capabilities. This process helped to identify their individual needs and choices, and was based on information supplied by social workers or healthcare staff. If the person was unable to contribute, information had been actively sought from others such as family members and friends. Written personalised care plans, which detailed people's individual needs and choices, had been put together by the staff and the person in receipt of the care where possible.

The staff we spoke with understood the importance of involving people in appropriate activities which helped people feel involved and valued. Staff told us activities were based on people's preferences, however, they did also say that finding time to provide activities was sometimes a problem, as other work, such as personal care always took priority. The daily notes in the care plan recorded what activities and events the person was involved in, however, the number and type of activities were limited, and included watching TV, listening to music and watching a visiting entertainer. We asked people if they ever went outside into the garden. Two people said that there weren't always enough staff available to help people get outside, with one person saying, "everything we do is done indoors." A family member said, "I come in most days and the staff are very nice with me, but you could do with more activities especially at the weekend, it can be very quiet." Staff talked with people and involved them in activities. However, a number of people at the home told us that there wasn't really a lot to do apart from watch TV. This was supported by comments made by family members. One said, "There's not a lot for people to do apart from sit in their room, and wait for someone to either visit, or pop their head round the door." Another said, "I expected there to be a bit more going on in relation to activities and entertainment, but it's very limited." We noted that entertainment and trips were organised by the home.

This was a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provider must ensure that people's needs are met in a person centred manner, and this includes ensuring that people's social and cultural needs are met.

We spoke to three relatives about the care planning process, and delivery of care, and they all were satisfied that the staff were following the guidelines set of in their relative's care plans, and that this had resulted in their relatives experiencing a good quality of life whilst living at the home.

The people we spoke with said that the care they received was delivered in accordance with their needs and wishes, and the written reviews of this care supported this view. The reviews showed that where possible, the person themselves had been involved, and if this wasn't possible, family members and others important had been consulted. The assessment and care planning processes were based on current good practice relating to the care and treatment of vulnerable people. Care plans held a lot of very detailed information about each person's health and care needs.

The home had a suitable complaints policy and procedure that was publicised in its Statement of Purpose and the documentation was provided to new people entering the home. A record of complaints was kept and examined. One family member said, "I have made several complaints since my relative has been here and yes, they did listen and they sorted everything out. But you need to speak up when you want something sorting." We reviewed the records relating to two complaints, and found that the organisation had liaised openly and honestly with the complainants, and provided them with up to date and accurate information relating to their complaint.

The home had appropriate processes in place to ensure that when people were admitted, transferred or discharged, relevant and appropriate information about their care and treatment was shared between providers and services. Information held within people's personal care records showed that liaison had taken place with other health professionals and a relative spoken with confirmed that they had been involved with the assessment process and had been kept informed at every stage. Written records were maintained and appropriate external contact details were logged. Staff at the home stated that confidential information was only shared about a person once it was established it was safe to do so. We observed this in practice when a staff member spoke to a relative over the telephone regarding a sensitive healthcare matter.

Requires improvement

Is the service well-led?

Our findings

The provider had systems and procedures in place to monitor and assess the quality of their service. These included seeking the views of people they supported through 'resident and relatives meetings', satisfaction surveys and care reviews with people and their family members. One person told us, "I think the home is well run now, and the new manager is very good." Another said, " I like living here as I get on with people, and the staff are always interested in me. I've lived in other care homes, but this one feels a lot better than the others. I think it is well run." The records relating to resident's meetings and satisfaction surveys were seen, and we found that people were enabled to put forward suggestions as to how to improve the home. These suggestions focused on communication between the staff, residents and relatives. Two relatives that we spoke with said that they thought communication had improved over the last 6 months.

The registered manager explained that she and the clinical lead for the home were involved in auditing different aspects of the service provided. We saw evidence of these audits, and saw that the system had flagged up areas of concern, and minor issues relating to care delivery and service provision. However, as we had identified issues such as a lack of social activities; a need to improve the environment for people with dementia and a need to revisit best practice on dignity, this indicated that the quality assurance and governance systems operated at the home, were not as robust as they should be.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provided must have an effective system in place to ensure that all the systems operated in the home can be robustly assessed and monitored all the relevant Regulations that apply to the home.

The people we spoke with (service users, staff and relatives) all said that the registered manager and management team provided good leadership. People also said that the registered manager was knowledgeable, and that she was able to deal with issues in a positive manner as they arose.

We found records to show that the service provider, or their representative visited the home, and undertook quality assurance checks through the analysis of incident and accident records, training record analysis, and environmental health and safety checks. The registered manager also received supervision from an area manager, during which quality assurance and governance was discussed.

Staff members confirmed that they received regular handovers (daily meetings to discuss current issues within the home). They said that handovers gave them current information to continue to meet people's needs, and updates regarding incidents, and what action to take to minimise or reduce the possibility of further accidents or incidents. Accidents, safeguarding concerns or other such adverse incidents were recorded, monitored and analysed. This enabled the management team to identify any recurring themes or patterns of adverse incidents, anticipate further incidents and to ensure that any learning from the incidents could be identified and shared with the staff team.

The staff we spoke with clearly understood the lines of reporting and accountability within the home. When we questioned staff they were able to give a good account of their roles and responsibilities with reference to keeping people safe, meeting people's needs and raising concerns regarding the quality of care provided at the home. Supervision files showed that staff were monitored and supported and knew what was expected of them in regards to their responsibilities. One member of staff told us "this is a nice place to work and I have on-going training, it is very relaxed and there is good support for everyone". To make sure people benefitted from up to date guidance and practice, information was shared with staff through regular meetings. The minutes of a recent staff meeting showed they had discussed the Care Quality Commission's (CQC) inspection of the home.

We found documentary evidence to show that risk assessments and safety plans were in place relating to different aspects of the home. For example: care planning, treatment, infection control, medication, fire, healthcare, environmental safety and staff training. We found a number of daily records to show that various people at the home had been involved in incidents that required notification to the Commission and/or the local Safeguarding team, and records to show that these notifications had been

Requires improvement

Is the service well-led?

processed and sent in a timely manner. All the records were seen to be stored securely, and only those authorised to access the records, did so, in line with the home's record keeping and data protection policy.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The service provider did not ensure that people's needs are met in a person centred manner, and this included ensuring that the building and environment was person centred and adapted to meet people's assessed needs, specifically those with dementia care needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We identified a number of key areas were improvement was required, and this had not been identified by the service provider's quality assurance systems. The service provided did not have an effective system in place to ensure that all the systems operated in the home can be robustly assessed and monitored all the relevant Regulations that apply to the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Although food and hydration was provided, people's preferences regarding food and mealtimes were not always fully considered, and further work was needed to ensure people's needs were assessed fully and met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	The service provider did not ensure that people's needs were in a person centred manner, and this needed to include ensuring that people's social and cultural needs were met.