Healthcare Homes Group Limited

Park House Nursing Home

Inspection report

27 Park Crescent
Peterborough
Cambridgeshire
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Tel: 01733555700

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Park House Nursing Home is registered to provide accommodation for up to 52 people who require nursing or personal care. The home provides a service for older people, some of whom are living with dementia. At the time of the inspection there were 47 people living in the home. The home is on the outskirts of the town of Peterborough. The home has two floors and the first floor is accessible by a passenger lift or stairs.

This comprehensive inspection took place on 19 July 2017 and was unannounced.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The registered manager was present during this inspection.

Risks to people who lived at the home had been identified and staff were aware how to reduce risks to people. However, the systems in place to manage or minimise the risks to people had not always been used. Audits in relation to care plans, risk assessments and fluid charts had not always identified all areas of improvement required.

People had their medication administered as prescribed. The provider's policy on administration and recording of medication had been followed by staff. Internal and external audits in relation to medication administration had been completed and were robust.

People had their needs assessed and reviewed. Staff knew how to support people and meet their requirements even though information had not always been recorded in people's care plans. People's care plans contained person centred information which detailed people's likes and dislikes and how they wished to be supported.

There was a system in place to record complaints. These records included the outcomes of complaints, that people were satisfied with the outcomes and how the information was to be used by staff to reduce the risk of recurrence.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and could describe how people were supported to make decisions. Training had been provided by the provider and staff were aware of current information and regulations regarding people's consent to care. This meant that there was a reduced risk that any decisions, made on people's behalf by staff, would not be in their best interest and as least restrictive as possible.

People were kept safe because there were sufficient numbers of staff to meet people's needs. The provider had a recruitment process in place and staff were only employed within the home after all essential safety

checks had been satisfactorily completed. Staff received an induction when they started work and further training was available for all staff which provided them with the skills they needed to meet people's requirements.

People and/or their relatives were involved in how their care and support was provided. Staff treated people with care and respect and made sure that their privacy and dignity was respected all of the time. Staff monitored people's health and welfare needs and acted on issues identified. People were enabled to access health care professionals when they needed them. People were provided with a choice of food and drink that they enjoyed. People, where required, were given the right amount of support from staff to enable them to eat and drink.

People, relatives and staff were able to provide feedback and information. There were systems in place to monitor and audit the quality of the home.

Staff meetings, supervision and individual staff appraisals were completed regularly. Staff were supported by the registered manager and deputy manager during the day. A management out of hours on call system was in place to support staff, when required.

You can see what 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.

People were not always kept safe, because their physical and health risks had not always been recognised or managed effectively.

People were administered their medication as prescribed.

People were protected from harm because staff understood what might constitute harm and what procedure they should follow if they thought someone had been harmed.

The recruitment process ensured that only suitable staff were employed.

Is the service effective?

Good

The service was effective.

People were supported to meet their needs by staff who had the necessary skills and competencies.

Staff had received training and understood the principals of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People had access to healthcare professionals when they needed them.

Is the service caring?

Good

The service was caring.

People's dignity, privacy and independence were respected. People were involved in decisions about their care.

People received care that was kind and caring.

Is the service responsive?

Good

The service was responsive

People were involved in the assessment and reviews of their health and social care needs. People received individualised support from staff who were responsive to their needs.

There was a system in place to receive and manage people's concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in place. Staff were supported by the registered manager and deputy manager.

Quality assurance systems were in place to assess and improve the quality of care for people but were not always robust.

People, relatives and staff were consulted about the home.

Park House 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place on 19 July 2017 and was carried out by one inspector and one 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. Their expertise was in relation to people living with dementia and older people's services.

We reviewed notifications received by the CQC. A notification is information about important events which the service is required to send us by law. We also looked at information we held about the home.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We reviewed the information to assist us with our planning of the inspection.

During the inspection we spoke with nine people living in the home and three relatives. We also spoke with the registered manager, deputy manager; one nurse; one member of care staff; one activities co-ordinator, and the catering supervisor.

We spent time observing the care provided by staff to help us understand the experiences of people unable to tell us their views directly. This was because some people were living with dementia.

We looked at five people's care records, quality assurance surveys, staff meeting minutes and audits. We checked records in relation to the management of the home such as health and safety audits and three staff files.

Requires Improvement

Is the service safe?

Our findings

People were not always kept safe, because their physical and health risks had not always been recognised and the level of risk to people had not always been managed effectively. These areas included poor skin integrity and the risk of choking. The use of recognised assessments, in relation to areas such as skin integrity (Waterlow) and the malnutrition universal screening tool (MUST), had been completed. However, information in the assessments had not been used to minimise the risks for people. For example, one person had been assessed using the Waterlow and there were major differences in the recorded scores from one month to the next. There was nothing in the person's file to show there had been any change in relation to their assessed needs or what had been put in place to minimise the risk. Another person had information on their file that showed they had poor swallowing reflexes. A note was made that the person should have 'thickener for drinks'. However, there was no information about the type of thickener, the consistency or amount to be used per liquid quantity. Staff were aware of those people who may have been at risk and knew what they should do to manage and minimise those risks.

There were records of accidents and incidents, which demonstrated that actions had been taken to reduce the risks of the person having similar experiences. For example, there had been an issue with people falling. We saw that referrals' had been made to the falls team and the GP. There was evidence that people had been asked to use the emergency call bells so that staff could support them. One person told us, "I try and walk in my room with my frame. My leg gave way the other day and a carer was nearby and helped me fall slowly. So now they say I need two people to help me at toilet time." Staff knew what to do in the event of an accident or incident. One staff member said, "I would fetch the nurse straight away unless it was more urgent and then I would ring the emergency bell. I have done that when a person has fallen. The staff came quickly."

People felt the home was safe. One person said, "I feel perfectly secure – we've nice staff and I can't see any burglar getting in." Another person said, "I refer to it as my home now – there's always someone about and I've no need to lock my door." A relative said, "The safe guarding is good here. [Family member] is checked on and I trust them [staff] and they know they can ring me any time."

Information from the provider in the Provider Information Return (PIR) showed that, 'The service has a safeguarding procedure in place and referrals are made, when appropriate, to Adult Social Care and CQC'. Staff confirmed that they had undertaken training in safeguarding people from harm and were able to explain the process to be followed if incidents of harm occurred. One member of staff said, "Abuse can be financial, physical or emotional. I would document everything and take it further to [name of registered manager or name of deputy manager]. Management would take it further. We [staff] can't promise people [living in the home] not to tell anyone [if harm was occurring]." Another staff member said, "Initially I would go to [names of registered manager and deputy], but we have the [telephone] numbers if we're seriously worried and wanted to deal with it straight away [if the registered manager or deputy was not available]." We saw that training records showed staff had received training in respect of safeguarding adults which was in line with the provider's safeguarding policies.

There were sufficient numbers of staff to meet the needs of people they supported and staff confirmed this to be the case. People and their relatives told us they were happy with the level of staffing and that their needs were met. One person said, "Yes, I think there's enough – I can't fault that." A relative told us, "Generally I think there's enough [staff] on at a time, but a weekend has fewer [staff on duty]." The activities staff said they had sufficient numbers and were 'well-staffed'. Staff told us that the managers had a rota to provide an out of hours system so that they could be contacted in case of an issue or emergency in the home. The registered manager said that a dependency tool was used so that they knew the number of staff to be employed and meet people's needs. Where necessary additional staff could be brought in if people's needs changed.

Documents seen in staff personnel files showed that safe and effective recruitment and selection processes were in place. These processes ensured staff were of good character, physically and mentally fit for the role and able to meet people's needs. We saw that staff only started work once satisfactory checks, including a criminal record check had been undertaken.

Information from the provider showed that, "Medication is stored safely. Staff responsible for the administration [of medication] received medication training and have had their competencies checked in the last 12 months." There was an annual pharmacy inspection on 20 June 2017 with actions to be taken by staff in the home. The deputy manager showed us the action plan and the improvements made as a result. For example, we saw that any allergies that people had were now highlighted on their medication administration record (MAR) chart.

People were administered their prescribed medications as detailed in the provider's policy on medication administration. Some people were encouraged, where appropriate, to manage their own medication. One person told us, "I self-medicate myself in my room where my tablets are locked away. I open up the packets myself. The nurse does a check when I say I need to re-order more tablets at the end of the month." Another person said, "The nurse waits by me while I have my tablets." We saw that medications that were 'as needed' had a protocol in place for staff to follow. Staff said that some people had capacity and had the ability to tell them if they needed the 'as needed' medications. There had been some issues in relation to time specific medications for people. However, we were told by people and their families that these had been addressed and now medications were always given at the correct time.

The deputy manager was aware that some protocols around medication that could be taken 'when needed' were not detailed enough. They had started to re write a number of the protocols and these were detailed and provided staff with the information they needed. The deputy manager said that all 'as needed' medication would have the new protocols in place as soon as possible.

There was evidence that updated medication training was taking place in the home during the inspection. Information from the provider, and staff confirmed that training in medication administration had been provided and they attended regular updates each year.

Information from the provider showed that there had been nine medication errors in the last year. There was evidence that appropriate action had been taken, which included competency checks for those staff who had made the errors. This was to make sure that staff were competent and confident to support people with their medication. The deputy manager told us that a new method of medication administration was being looked into to ensure the issues of medication errors did not reoccur.

Good

Is the service effective?

Our findings

People spoke positively about the training that staff completed. However, some felt agency staff were not as well trained as the home staff. One person said, "Most [staff] are good at their job, but agency ones (staff) often don't know what they're doing. Staff have to show them which then holds them up." One relative said, "The staff seem to know what they're doing when they hoist [family member]. They're very encouraging to [family member] and he trusts them."

The provider told us in their PIR, "All new staff members are required to attend a four day corporate induction course which is trainer led and organised to deliver knowledge in line with the Care Certificate. Induction training will continue in the initial three months' probation period with a series of e-learning subjects and direct coaching and mentoring by experienced staff. The [registered] manager will review new staff progress during induction/probation period in a series of supervisions and probation reviews." Staff members told us that they had completed training on line (computer). Information showed that diversity and equality, dementia awareness, medication and fire safety had been completed by staff. Most staff had completed their practical moving and transferring training. There was a training plan in place which identified when staff needed to complete the updates for on-line courses. This meant that people were being looked after by staff who had received some training to support and meet the needs of people living in the home.

Nurses who required regular validation had been supported to complete the necessary training. One nurse told us they received regular one to one clinical supervision from the registered manager. This meant people received care from nurses who had their practice updated and discussed.

Staff told us that they had attended regular face-to-face supervision sessions and records showed that this was the case. One member of staff said, "I have recently had a supervision. It covers things like training, holidays, a chat about how things are going, discuss the way forward and if there are any concerns." Staff said that they were offered support at any time if they needed it. One staff member said, "They [managers] are listening to us."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that they were able to make decisions about their wellbeing. One person said, "I can go where I like up or down and can go out in the garden too. I can decide if I want to do entertainment and I can have lunch in my room if I prefer some days." Another person said, "I can do whatever I like – I make my own decisions."

Staff understood how people's rights were being protected. They were able to demonstrate sufficient knowledge about the Act and its key principles. As a result we were confident that people's rights were being fully protected. This was because staff were aware of how the Act impacted on people, how information should be recorded to check people's best interests and the areas that they may or may not have capacity over. One staff member said, "I have had training in the Mental Capacity Act and DoLS. It is that people might have capacity to make decisions about some things, even at certain times of the day, so they should make their own choices where they can." Another staff member said, "It [MCA and DoLS] is legislation to protect vulnerable people who are unable to make certain decisions for themselves. We presume a person has capacity and it will protect carers. It is about giving informed choices." They went on to say that the choices they could provide to a person were through knowing the person's likes and dislikes. They felt that the information would help staff provide appropriate choices later if a person's capacity diminished.

We saw information in people's care plans in relation to their capacity to consent for personal care or to have medication administered. We saw that one person had information on their care plan that showed they and their family had been part of a best interest meeting in relation to decisions about their medication administration.

The deputy manager confirmed that 23 DoLS applications had been authorised and further referrals had been made to the appropriate agencies to carry out DoLS assessments for other people. There was evidence that some authorised DoLS had written conditions and these were being met. The deputy manager said that Independent Mental Capacity Assessors (IMCA's) advocates were used when necessary. This was to help those people or families who may wish to request external help and information. IMCA's were also used to ensure people had a voice for when they had no other independent representative to advocate for them.

People told us that staff asked their permission before care was given. Comments included, "They definitely ask me beforehand, which is nice," and "They check with me first before doing anything." We observed staff asking for consent before attaching clothing protectors at lunch. Likewise, consent was sought before people were taken for personal care.

People told us that food provision was generally good, with choices and alternatives available and special diets catered for. One person said, "The food is alright – we have a laugh at mealtimes. The menu choice is fine." Another person commented, "It's good food – I've never had a complaint at all. They go out of their way to please us. They'd make us an extra snack if we wanted something between meals." However one person did say, "Just sometimes it could be better maybe. They will do you a third choice if you want something different."

People's individual dietary needs were catered for. The catering supervisor said they discussed people's likes and dislikes with them individually. If there were any special requirements made by the speech and language therapists (SALT) or dieticians the deputy manager provided that information. This ensured people received the correct diet to meet their requirements. Soft and pureed foods were available for people who had difficulty with swallowing. People who were at risk of unintentional weight loss were offered fortified foods (calorie rich) and nutritional supplements, and kitchen staff were aware of who required this additional support. One relative was positive about the care given for their family member. They said, "[Family member] has puree food now and is not always alert enough to swallow. If [family member] doesn't

eat, they'll tempt him with other things like Weetabix with cream or make some angel delight."

We saw that people had water available in their bedrooms. Drinks were served regularly and there was squash, water and wine available at lunch time. One person said, "I like the glass of wine with lunch – a nice thought even if we don't drink it. We've only to ask for a drink if we're thirsty." Other people commented, "They're [staff are] always coming round with drinks. My favourite tipple is [named soda drink]" and, "I've water in my room and have coffees in the day. They give us a milkshake from the trolley too every day."

Food and fluid charts had been completed for people who were at risk of malnutrition and/or dehydration. They showed the amounts people were eating and drinking together with the running total. One nurse told us that the night nurse checked the completion of the charts and that care staff were expected to inform the nurse in charge if people did not have wet continence pads when providing personal care. This meant there were other methods to check that people were not dehydrated.

Access to healthcare was pro-active, with people also able to use their own practitioners if preferred. People told us they regularly saw the chiropodist and optician. One person said, "The doctor comes to visit me for check-ups on my pain." We saw evidence that relevant health professionals such as dietician, SALT, tissue viability nurse (TVN), falls team, mental health services and GP as well as access to services such as a hairdresser.

Good

Is the service caring?

Our findings

People and their relatives told us they were very happy and the care they received from the staff in the home. One relative told us, "We had a choice of three homes that we looked at and it was best here – quieter and more like a family home than a care home." People were cared for in a kind and compassionate way by staff and people's privacy and dignity was respected. We observed staff interacting well with people, often sharing a joke or conversation. One example was a member of staff coming to return a person after a hairdressing appointment. She put her arm around the person's shoulder and said, "Oh my, doesn't your hair look lovely. You'll be the belle of the ball at the garden fair this afternoon." The person smiled happily.

People said staff were kind and made comments such as, "They're [staff are] very nice and we get some laughs together," "I find them [staff] all charming" and "I find them wonderful." People felt listened to and commented, "I feel very happy with them [staff] and I can open up to them if I've a worry," and "I've not been here long but already feel relaxed with them [staff] all."

Although people commented that they had not seen their care plan they agreed that they and their relatives had been involved in the planning of their care. One person commented, "My sons do my business for me and have been here for a manager meeting."

There were details of independent mental capacity assessors displayed in the foyer. Details of other advocacy services could be provided should people want them. Advocacy services are independent and support people to make and communicate their views and wishes.

People's privacy and dignity was respected. One person said, "They always knock, even if my door's open. The nurse or carer closes my curtains. I laugh but they say they have to for my privacy." One relative commented, "[Family member] would only allow my [relative] to bath her initially as she's quite private about that sort of thing. But gradually the girls [staff] have won her over and she'll let a few of them take her [for a bath] now. They're very respectful with her."

People were encouraged to be as independent as possible. We saw that people could move between the ground floor and first floor in the home as well as out into the garden. Some people were able to do so unaided or were supported where necessary. People said things such as, "They let me do as much as I can and come and go when I want," "I can take myself to the garden and have freedom to let myself in and out" and, "They set up everything for my wash then let me do as much as I can reach."

People told us their family members could visit them at any time. One person said, "My family can come any time." One relative commented, "They suggest between 1030am-8pm but it's flexible, especially if someone is ill."

Good

Is the service responsive?

Our findings

Information in the PIR showed that 'prior to any service user moving to Park House, an initial pre-admission assessment is carried out by the management team. This is to ensure that a safe admission will take place and that the home [staff] can meet the service user's needs.' They went on to say that care plans had the person at the centre of the assessment and that care plans were reviewed and updated on a monthly basis to ensure information was current for staff to be able to meet people's needs. The deputy manager was aware that some care plans and reviews were better written than others and was working through all the care plans to ensure they were fully completed, up to date and written well. This would be done as soon as practicable.

People told us that they or their families were involved in planning their care. However, no-one we spoke with could recall seeing their/ their relative's care plan. One person said, "My family are local and do it all for me – they get a regular meeting and seem to know what's going on with me." Another person said, "They [staff] did a lot of paperwork when I came [into the home] and my son and daughter are involved with it all." A relative told us, "[Another family member] and I have both power of attorneys so we talk with the office [staff] and keep involved that way. I've not seen her care plan before though."

We saw that care plans had been written in a way that showed what the person could do and also the support they may need. They also detailed more personal things such as a person's likes and dislikes, family history, previous work, activities/hobbies and interests. For example, one person told us they had a butterfly quilt on their bed because staff were aware that they liked butterflies. Other people told us that any preference of male or female staff was respected. One person told us, "They did ask me, but I don't mind who. We have a very nice male carer." One relative said, "They did ask the question and Mum said no males, which is respected."

We saw that care plan reviews had been completed monthly. In two people's care plans we saw that changes in the area of their health had not been updated and recorded. However, in talking with staff it was evident that information was shared regularly, so that they were kept up-to-date about changes in people's needs. For example, staff told us there was a daily handover meeting for registered nurses and for care staff so that they were updated about any changes for each person in relation to areas such as medication, mobility and people's general wellbeing. This meant staff were able to provide the care people needed.

One person's relatives told us that they had been listened to and that their family member had moved to the ground floor where, "[Family member] is more settled here as it's quieter and has the garden view. She has her bird feeder outside her window too that we re-fill. She loves watching the squirrels and birds." Another relative told us, "A lovely member of staff came with [family member] to our [relative's] wedding so that he could go for the ceremony. I thought that was so kind of them." A third person told us that their family member had been surprised that, "[Family member] had only been in here three days and it was his birthday. All the staff came in [to the bedroom] and sang Happy Birthday and gave him a big cake, which got shared round. He was so surprised. I thought it was a lovely thing to do."

People were positive about the activities provided in the home. One staff member told us there were six activities staff who covered seven days a week. There was information in the home that showed there was a dedicated activity programme for each floor, including one-to-one activities. A weekly activity programme sheet was given to each person living in the home, and also displayed on noticeboards. A monthly newsletter was also produced for people and their families. One person told us, "I'm not a quiz person but the musical events are good. If there's nothing on I fancy, I read or have got my TV and Sky Sports – I'm a football fan." Another person commented, "We chat in the lounge. We can join in games and things if we want. The garden is lovely." People told us of other activities such as art and crafts, sewing and knitting, outings to the garden centre or shopping and the park.

There were church services for 'spiritual support' for those people who wanted to attend. One relative was positive about the encouragement provided to their family member and commented, "He'd stay in bed all day if he could so they'll get him up to go outside if they can. They ask but often he'll say no from habit so they jolly him along in other ways." In the afternoon of the inspection we observed a garden activity run by 4 activity staff – a village fair. 15 people and a family were participating in activities such as hook a duck, hoopla, a parachute game, name the teddy bears, ping pong ball throwing and bubble blowing. Ice cream cornets were served. We saw very good examples of staff interaction and inclusion of people of all abilities. There was a lot of laughter too.

People knew how to make a complaint and the provider had a policy and process in place to investigate and action concerns where necessary. Where people had made a complaint, these were in the process of being dealt with or had been addressed to the satisfaction of the person. One person said, "A few of us made a joint complaint that the menu gets a bit monotonous, so they're looking at it and will discuss it at the next meeting." Another person said, "I've not really had to make a complaint. Little things are easily ironed out."

Requires Improvement

Is the service well-led?

Our findings

We checked to find out how the home was being managed. There was a registered manager in post. The registered manager was supported by a deputy manager, nurses, care staff, ancillary staff and a regional manager.

The provider had a system in place to monitor and improve the quality of the service. There was an audit process to check the records in relation to areas within the home such as care plans, risk assessments, medication administration, food and fluid charts, concerns and complaints and accidents and incidents. There was evidence that audits in relation to concerns and complaints and accidents and incidents had been analysed to minimise the risks for people in the home and improve the service provided. Medication audits had recognised that medication taken 'as needed' had a protocol in place. However in discussion with the deputy manager they agreed the information was not detailed enough and had started to review and rewrite them during the inspection. Risk assessments and care plans had not always been updated appropriately when there had been changes in a person's health. Also information about the minimum fluid people should drink was not incorporated into the chart and therefore staff would not always be aware of the necessary levels. This meant that the audits were not always as robust as they should have been and therefore issues had not always been actioned to improve the service. The deputy manager and registered manager were made aware of the concerns and immediately started to make changes in relation to the records of fluid intake and to re-write the care plans and risk assessments of people whose health needs had changed.

The provider aimed to operate an open and transparent culture. In their PIR they wrote, "There is an open door policy and the [registered] manager will be visible. This encourages service users, relatives and staff to express any concerns they might have." Our discussions with staff showed that the managers were easy to talk to about anything. Staff felt they would be treated with respect and listened to about any issues they wanted to raise. There was an openness, which ensured a positive culture within the home.

People felt that the home and the staff were, "Happy and friendly," "To me it's home from home – very peaceful" and, "It's just lovely. Nice people and comfy accommodation." One member of staff said, "It's a nice, small, friendly nursing home. It's well managed."

Staff were aware of the provider's whistle blowing policy and procedure and said they would report any poor practice if they needed to. One member of staff said, "It's when you privately report something, any concerns, anything you're worried about. It would be dealt with." Another staff member said, "There are [telephone] numbers to contact if we see something we don't like [in relation to poor practice]."

People and their relatives we spoke with could not recall being asked for written customer feedback. Comments were made such as, "I've never had any request to write comments," "No little survey as far as I know" and a relative's comment, "I don't recall any questionnaire type things." However, we saw that people, their relatives and staff were consulted about the quality of the care and support provided to people. Surveys had been sent out and collated in November 2016 into the Park House Quality Assurance

Survey 2016. Information from the survey showed that food quality, participation of people and their relatives in their care plans and reviews and the registered manager's communication with staff to encourage 'team working' were some of the areas of improvement needed. We saw that an action plan had been written and action taken. For example, the cook now attended 'residents and relatives' meetings; the registered manager had regular meetings with the head of every department every week and a new system had been used so that the registered manager could send messages to staff when they signed in or out of the computer system. This meant people, relatives and staff had been listened to and action taken to improve the home.

A provider quality visit had taken place in May 2017 and showed that an action plan had been put in place in relation to a number of issues identified. The actions to be taken were recorded and signed off as complete where that had been done. We found there had been improvements, such as the 'visibility' of the registered manager. One person said, "He's great. He puts his head round every morning to say hello and uses our Christian names, which is lovely. He's very nice to talk with." A relative said, "He's very approachable and listens to me if I need any information." Other people and relatives said the deputy manager was "very good and easy to talk to." The staff commented that the managers were "excellent" and "very open". This meant that the provider's quality monitoring system was thorough enough to monitor and drive forward the necessary improvements needed. This meant the provider had the ability to respond to situations as quickly and effectively as possible.

People and their relatives told us that regular meetings were held in the home and that topics raised were noted by management and acted upon. The last meeting held was on 6 July 2017. Minutes of these were seen. There were discussions about a number of subjects, such as a change of catering supplier and a request that people feedback any positive or negative comments; information about activities and new entertainers; transport for outings and information on staff vacancies in the home. There had been no actions necessary after the last meeting. One person told us, "They do have meetings – food and activities are often topics and they take what we say on board." Another person said, "I went to a meeting the other day and found it interesting. There were no complaints raised funnily, it was all positive stuff about here (the home)." A third person said, "They encourage us to talk up."

Staff said there were regular team meetings such as staff, registered nurses and activities staff. We saw a number of meeting minutes. The minutes for the activity team for 4 May 2017 discussed planning summer activities. For example, a picnic in the park opposite the home and a 'fun of the fair' afternoon. There was information that the registered manager had attended to explain new policies and legislation. The registered nurses meeting held on 26 June 2017 discussed care plans, 'resident of the day', helping between floors and a discussion about 'as needed' medication and refurbishment of the medication room. The staff meeting held on 22 June 2017 showed that information was shared that the fire inspection was satisfactory, long service awards were discussed, maintenance issues to be brought to the registered manager's attention and staff discussed wearing a plain T shirt if the weather reached 24 degrees. This showed that the meetings were also used as a forum to ensure that staff understood their responsibilities and what was expected of them.