Prestige Care Limited

Parkville Care Centre

Inspection report

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Date of inspection visit:
16 October 2018
17 October 2018

Date of publication:
21 November 2018

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

This inspection took place on 16 and 17 October 2018. The first day of the inspection was unannounced, which meant that the staff and provider did not know we would be visiting. The second day was announced.

Parkville Care Centre is a purpose-built care home located in central Middlesbrough. It comprises of two buildings, both have two floors. This service provides support and accommodation for up to 93 people assessed as requiring residential or nursing care. This includes support for people living with a dementia type illness. At time of our inspection there were 69 people living at Parkville Care Centre.

Parkville Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

During this inspection we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) relating to Safe care and treatment.
You can see what action we told the provider to take at the back of the full version of this report.

This is the first time the service has been rated Requires Improvement.

We observed one occasion where staff transferred a person using an unsafe technique. We brought this to the attention of the management team who took appropriate action to address the issue. All other observations of transferring people were carried out by staff in a safe and competent way.

Medicines were not always managed safely. We could not be confident that people had received their medicines as prescribed. This could put people at risk of ill health. Medicine records were not comprehensive. Medicine audits had not identified most of the issues we found in this area.

Policies and procedures were in place to support staff in protecting people from harm, such as safeguarding and whistleblowing polices. Staff knew how to identify and report suspected abuse. People and their relatives felt the service was safe.

People's files contained the information staff needed to support them. Risks to individuals were documented with information available for staff in how to manage these to reduce risks to people. Risk assessments were reviewed on a regular basis.

Most people and their relatives told us that there were sufficient numbers of care staff on duty to ensure people's needs were met. Some staff felt that the service would benefit from staffing levels being increased. The management team used a dependency tool to ascertain staff levels were sufficient. During this inspection we saw call bells were answered in a timely manner.

Safe recruitment practices were in place. Pre-employment checks were made to reduce the likelihood of employing staff who were unsuitable to work with vulnerable people.

Staff said that they received regular supervision. We received mixed feedback from staff regarding how supported they felt by the management team.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, some additional work was required with record keeping in this area.

People had access to, and the service worked with, a range of healthcare services such as GPs, hospital departments and dentists. People's nutritional needs were met.

The premises were spacious and tidy. One of the two buildings had been updated and adapted to meet the needs of people with a dementia type illness. We were informed by the provider that they planned to update the other building to improve people's surroundings.

Staff knew how to help control the spread of infection. Equipment and building checks were undertaken to help ensure the environment was safe. Emergency contingency plans were in place.

People were supported by a regular team of staff who were knowledgeable about their likes, dislikes and preferences. Visitors told us that they were made very welcome. Staff members were kind and caring towards people. People's privacy, dignity and independence were respected. Staff encouraged people to access a range of activities and to maintain personal relationships.

The policies and practices of the service helped to ensure that everyone was treated equally. Care plans included information about people as individuals including their preferences. End of life care procedures were in place which recognised the needs of people and their relatives at this important time.

Feedback was sought to monitor and improve the service. Meetings for people and staff took place regularly.

Learning took place following reviews of accidents and incidents where themes and trends were addressed. A clear complaints policy and procedure was in place.

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.

We identified staff using an unsafe transfer technique during this inspection.

Medicines were not always managed safely. We found gaps and inconsistencies in medicine recordings.

Staff had been trained in safeguarding people and were knowledgeable about the potential signs of abuse.

There were enough staff available to meet people's needs. Recruitment practices helped ensure suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff had the training they required to meet the needs of people they were supporting.

Consent was sought from people before tasks were undertaken however additional work was needed to ensure all best interest decisions made for people who cannot make their own decisions were recorded correctly.

Care plans included information for staff about how to support people as individuals. Staff were knowledgeable about people's needs.

Is the service caring?

Good

The service was caring.

People and their families told us staff were very caring.

Staff were kind and patient in their interactions with people.

People's independence was promoted.

Relatives told us they were made very welcome.

Is the service responsive?

Good

The service was responsive.

A wide range of activities were on offer to people living at the service.

People knew how to complain if they needed to.

End of life policies and procedures were in place for when they were needed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems were in place however they had not identified the issues we identified during this inspection.

People and their relatives were provided with opportunities to provide their feedback on the quality of the service.

The management team were open and keen to address the areas of improvement identified during this inspection. They were responsive in addressing the issues highlighted

Parkville Care Centre

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 comprehensive inspection took place on 16 and 17 October 2018 and was carried out by an inspector, an assistant inspector, a pharmacy inspector, a specialist nurse advisor and two Experts 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 contacted the commissioners of the relevant local authority, the local authority safeguarding team, the fire service and other professionals who had worked with the service to gather their views on the service being provided at Parkville Care Centre. We used the information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed all the information we held about the service, which included notifications submitted to Care Quality Commission (CQC) by the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

During the inspection we spoke with 15 people and 10 relatives of people using the service. We reviewed a wide range of records, including 14 people's care records and 16 people's medicines records.

We looked at five staff files, including recruitment details, supervision, appraisal and training records. We looked at a range of records relating to the management of the service and a wide variety of policies and procedures. We spent time observing people in the communal areas of the service.

We spoke with 16 members of staff, including the deputy manager, seven care staff, an activities coordinator, a nurse, two domestic staff, one member of the catering team, the maintenance person and

two of the provider's representatives.

Requires Improvement

Is the service safe?

Our findings

During this inspection we saw staff assist a person using an unsafe people movement technique whilst trying to respond to the person's wishes. Although the staff were attempting to act in a person-centred way, incorrect moving and handling techniques could put people at risk of harm. We brought this to the attention of the management team who took the appropriate action to address the issue. Records showed that the staff team had received recent moving and handling training. The service had a moving and handling champion whose role was to share good practice with the staff team. During conversations with us they could explain the correct ways to transfer people and confirmed staff had access to necessary equipment to support people to transfer safely. Other observations of moving and handling procedures showed competent and successful practice.

Medicines were not always managed safely. We looked at the systems in place for medicines management and found they did not keep people safe. We looked at six medicine administration records and found that 15 medicine stock counts did not match with how many administrations were documented. Therefore, we could not be sure medicines were administered as prescribed.

Topical medicines, such as creams and ointments were not applied as prescribed. We looked at 16 records in this area and found they were either incorrect, not in place or administration had not been recorded. For example, we looked at one record where care staff had signed to say they had applied an anti-fungal cream yet the person was not prescribed this. We also found staff with no medicine training were applying prescription only creams. Therefore, we could not be sure people's creams were being applied as prescribed.

We looked at how the home managed application of patches and found they were not following their current medicines policy. For example, we looked at one person who was prescribed a patch for pain; manufacturers guidelines state this patch should be rotated at each application and the homes policy also stated that a patch application record should be in place however the home could not provide such records to demonstrate that the patch had been rotated appropriately.

Medicines which required cold storage were kept in fridges within the medicines store rooms. The provider had a clear policy in place regarding temperature monitoring however this was not always followed by staff; for example, minimum and maximum temperatures were not recorded on all units. One fridge showed a reading outside of recommended temperatures but no action had been taken.

There was not enough information about 'as required' medicines to enable staff to know when people needed them. For example, we looked at one person who was prescribed a medicine for anxiety, whilst there was a protocol in place it did not specify in detail when this was to be given or any de-escalation techniques to be used before administration. Records detailing the reason for administration of this 'as required medicine' did not show that it had been given in line with prescribed instructions.

Staff had not adequately communicated with prescribers when people refused their medicines. We were

told by staff that one person did not like waking up early or would sometime refuse food making it difficult to administer medicines covertly however this was not documented. After the inspection the home informed us that this had been escalated to the prescriber for review.

Medicines audits were carried out regularly but had not picked up everything found on inspection. The service had made efforts post inspection to action the issues found, for example new fridge monitoring forms and reviewing processes for topical creams however we could not see the full effects of these changes until they become embedded in practice.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 related to safe care and treatment.
We asked people and relatives if they felt Parkville Care Centre was safe. One person said, "I've lived here for a year now and always feel safe because the staff have all the patience in the world with me." Another relative said, "My spouse has been in a number of care homes and this is where we both know [person] is well cared for and safe."

Systems and procedures were in place to reduce the risk of people being abused. Staff received training in safeguarding. Staff we spoke with understood how to keep people safe including what to do if an allegation of abuse was made. They were aware of whistleblowing procedures. They informed us that they were confident the management team would respond to any safeguarding concerns raised.

People and their relatives told us there were enough staff on duty to support people with their needs. One person told us, "I've lived here for over five years now and I've always felt safe because the staff are always on hand to help you." Another person told us, "During the week there seems to be enough staff on but it's a bit quieter on weekends and at night, but I've had no problems." A relative told us, "Yes, every time I've visited over seven years there have been plenty of staff about the home." During this inspection we saw that call bells were usually answered very quickly. One person said, "I only use the bell very rarely and only when I have to but they get to me quickly usually." Another person told us, "I used my call bell earlier today and the carer was there quickly but sometimes you can wait, depending on how busy they are."

We talked with staff about staffing levels. Some staff told us that they were very busy saying, "There's four of us, but I would say we need more than four up here, it's a hard floor" and 'We have four members of staff to the floor, I think we could do with five constant members of staff to the floor. It's just a busy floor and that way we get to spend more time, instead of being rushed." The management team assessed staffing levels using a dependency tool which reviewed people's needs monthly. Staffing numbers met the services dependency tool.

Safe recruitment procedures were in place and followed. Staff completed an application form and any gaps in their employment history were checked out by the provider. Two references were obtained prior to staff starting work at the service. A Disclosure and Barring Service (DBS) check was carried out before staff commenced work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people from working with children and vulnerable adults.

People's care files included the information staff needed to support them. General risk assessments were in place to try and ensure that risks to people were reduced. Risks to people such as diabetes, falls and pressure damage had been identified and control measures had been put in place to reduce the risks identified.

Regular fire drills had taken place. Records confirmed that the fire alarm was tested on a weekly basis and fire equipment was serviced regularly. People had Personal Emergency Evacuation Plans (PEEPs) which informed the staff of how to help them leave the buildings quickly in case of an emergency. The service had a smoking room which people living within the home used. The service's fire risk assessment stated that people would only smoke outside of the building. We brought this to the attention of the management team who informed us they would address this issue and that the smoking room was going to cease being used shortly.

Contingencies were in place to help keep people safe in the event of an emergency. The provider had a business continuity plan which set out how people's needs would continue to be met in the event of an unforeseen incident such as loss of utilities or telecommunications. Staff had guidance on who to contact in the case of such an emergency.

Equipment was maintained in line with manufacturer's recommendations. Checks were made on items such as lifting equipment, call systems and people's wheelchairs to ensure they were safe to use. Records showed that regular maintenance checks of both buildings took place.

Infection control policies were being followed by staff in their day to day practices, such as wearing gloves and aprons to help control the risk of infection. Staff told us that they had experienced some shortages of personal protective equipment such as gloves at times but that this had improved recently.

The deputy manager gave us instances of how lessons had been learnt from incidents. For example, following an accident person had in a shower changes had been made to procedures in this area.

Records showed systems were in place for reporting, recording, and monitoring significant events, incidents, falls and accidents.

Good

Is the service effective?

Our findings

Staff had the training they needed to carry out their roles effectively. One person told us, "I don't know what training they do, but they are always training, they use the lounge, they are first class in my opinion." A relative told us, "Yes, from what I have seen they are well trained and I think they are amazing as I couldn't do half the things they do."

Training was well managed. Staff completed training which the provider deemed mandatory, such as first aid, moving and handling and infection control. They also were encouraged to develop their skills and knowledge by undertaking additional, more specialised training to meet the needs of people supported. For example, during this inspection we saw that some staff were training to become care home assistant practitioners (CHAPS). The role of CHAPS is to bridge the gap between nursing and care staff and it is a career development pathway opportunity for experienced care staff who already have a NVQ Level 3 qualification. Whilst completing this course care staff learn how to support nurses with certain duties potentially freeing nurses to deal with the more complex issues.

New staff completed inductions. The management team signed them off when they were assessed as competent. This helped to ensure recently recruited staff were suitable for the roles in which they had been employed.

Staff told us, and records showed that, they received regular supervision from the management team. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed the care home was following the requirements of the Act regarding DoLS. We spoke to staff and they showed an understanding of the principles of the MCA.

One person told us, "I can speak to the staff any time that I want to about my care and I've had no problems at all and everything is fine." Another person said, "I look after my own care needs and the staff are always interested and listen to what I say." A relative told us, "My parent would not be able to make decisions on their own so we both go to any important care meetings."

For people who did not always have capacity, mental capacity assessments had been completed for their care and treatment and some decision specific MCA assessments had been completed for the covert administration of medicines. However, we found some best interest decisions were not documented for people unable to consent in some specific areas such as the use of lap belts and bed rails. The provider sent us evidence after this inspection that this work was being undertaken.
Some people had made advanced decisions on receiving care and treatment and 'Do not attempt cardiopulmonary resuscitation' (DNACPR) orders had been completed appropriately and signed by the person's GP.

The care records we looked at demonstrated how people's needs were assessed on admission to the service and then on a regular basis. Staff recorded how people had been throughout the day and overnight and records included information about care and support that had been given.

People's nutritional health was monitored using a screening tool (MUST). MUST identifies adults, who are malnourished, at risk of malnutrition (undernutrition) or obese. MUST assessments and weight recordings in the files we viewed were up to date.

People were supported to maintain a balanced diet We asked people about meals, snacks and drinks. One person told us, "The food is so and so, it just depends what's on the menu but if you don't like something they will make you something else, it's not a problem." Another person said, "The cakes here are to die for, well not literally but I would walk a long way to have one with my cuppa." A relative told us "The food is very good. I've had a couple of meals here which were really very good. Especially last Christmas." Families were welcome to join people at meal times. Snacks were available to people should they want them.

We observed the dining areas over lunchtime and saw that the food appeared appetising, hot and well presented. People who required assistance with their meal were appropriately supported and were not rushed. Food menus offered people choice. We saw one person declined both options on the menu. Staff reverted to their knowledge of the person and offered them a cereal option instead which they accepted. The lunch menu was in a pictorial format however, this was incomplete. Catering staff told us they were awaiting more pictures of food options to complete menus.

Catering staff spoke to people to gain feedback about food. Feedback was also sought by the activities coordinator during meetings with people in case people felt uncomfortable telling catering staff directly. Staff were aware of people who had dietary requirements such as needing a softer diet, fortified diet or religious preferences. Menus were altered menu's appropriately to meet people's needs in this area. One person told us, "I don't eat beef, it's against my religion, so they offer me bacon or ham." This matched the information documented in the person's plan of care.

People could access support from external professionals to maintain and promote their health. Where needed staff supported people with routine health care appointments. One person told us, "If I need a doctor the staff always organise this for me. I've had a flu injection and I do use the chiropodist when I need to." People's records contained information on communication with professionals such as GPs, district nurses, the falls team, dentists and hospital departments. We saw that appropriate referrals had been made where an issue was raised. One relative told us, "We get calls if our relative is unwell and the manager always ensures a quick visit by a GP or district nurse."

Some areas of the two buildings had signage and themed areas to help people find their way around but not all. One building had been newly renovated. The provider shared with us their plan to make improvements to the other building where some areas required new flooring and redecoration. People's bedrooms were

personalised with their own belongings to make them feel at home. The design of the buildings did not restrict the use of equipment to aid people's mobility.

Good

Is the service caring?

Our findings

People and relatives highly praised the staff at Parkville Care Centre. People told us they felt staff were very caring and they were happy living there. One person told us, "All the staff all pop in for a chat. I am not lonely here, it is like a big family home." Another person said, "I love the fact that a carer sits and has their lunch with us, it reminds me of family meals at home." A relative told us, "The staff are very caring." Another relative told us how staff always spoke very gently to their relative who was ill and how a staff member had come in on her day off to sit with the person.

We observed that staff provided support in a kind, patient manner. They explained what they were going to do before doing it and gave people time to think and respond. When needed staff would repeat or simplify what they were saying to people to ensure their understanding of what was being discussed. We saw staff interacting with people in a light-hearted manner when it was appropriate for them to do so. A relative told us, "They are always sharing jokes and [name of relative] loves it."

People's privacy and dignity were respected by staff and they made efforts to promote people's self-esteem. One person told us, "The carers are very pleasant and always seem caring towards me and if I need personal care they always close the curtains and door to my room. They always ask if it's ok to do things beforehand." Another person said, "They are always very polite and respectful, not only to me but to everyone." A member of staff told us, "Any sort of personal care, anything like that is always done inside the room, if we feel anything personal is going to be discussed we will take them somewhere where there is no ears or eyes. And I think it's doing little things like their hair and that and making sure they look nice and are comfortable."

The staff we spoke with could give detailed histories of the people who used the service, including their likes, dislikes and the best way to approach and support the person. We saw from their interactions that staff knew people very well. For example, we saw a staff member chatting with a person about when they were young and they knew details of the person's extended family. Care records included people's life stories. Staff could use the details of these to engage people in conversations and activities. People told us that they were supported to maintain contact with their family and friends.

Where people were anxious or in need of comfort staff interacted with them in a compassionate way. For example, we saw people being given dolls to nurse to help them feel more relaxed. We observed staff successfully giving lots of gentle reassurance to a person who was frightened of being moved. Through doing this they supported the person successfully. Staff were observed listening and responding to people's needs. For example, one person wanted to go to the lounge in the afternoon but was nervous about going by themselves. The staff member took the person's hand, found a seat and sat with them to listen and chat.

We observed staff encouraging people to be independent and undertake as much as possible for themselves. For example, whilst people were dining staff asked them, "Would you like me to tuck you in or would you like to do it yourself." We spoke with one person who was encouraged to engage in community activities safely and independently, the service had ordered the person a taxi to attend a local day centre he

enjoyed visiting twice a week. Another person told us, "I go into Middlesbrough town centre whenever I want to do my shopping and the carers encourage me to do this."

People told us that their voices were heard when it came to the running of the home. One person said, "I go to every one of the resident meetings and I speak out for a lot of people who can't speak for themselves, we chat about issues in relation to the home." Advocacy information was available for people if they required support or advice from an independent person. An advocate acts to speak up on behalf of a person who may need support to make their views and wishes known. Records were kept of advocacy visits.

Good

Is the service responsive?

Our findings

People's care needs were assessed before they moved into the service to make sure the service could meet their individual needs. Following an assessment, plans of care and support were developed to record how to provide the care the person required. Care plans covered areas such as personal care, communication, dietary needs and social activities and were reviewed monthly. They indicated that where possible people should be encouraged and supported to do as much for themselves as possible.

The plans of care we viewed provided staff with guidance about the best way to support people and reflect their identity. Staff told us they felt they had enough information available to them to care for people well. We saw that where they could be, people had been involved in agreeing their plans of care. One person told us, "I talk to the carers regularly about anything I need, so I'm happy with this arrangement." Another person said, "I plan my care needs with the carers and we speak daily." A relative told us, "My parent can understand the care plan meetings but prefers some support so I go along."

Care files took into account people's individual preferences and choices and included a 'family tree' of the people important to the person. People's likes and dislikes were recorded in areas such as food and choice of clothing as well as preferred routines. For example, for one person we saw that they liked to watch TV in their bedroom on a night and go for a smoke before breakfast. Another person's plan of care around their anxiety included details of how the service's sensory room helped the person to relax. Care plans reflected peoples changing needs for example, when their falls risk had increased.

Staff completed training in equality and diversity and the provider had an equality and diversity policy in place. People's religious, cultural and spiritual needs were identified and recorded in their pre-admission assessment. One person told us, "The clergy come into the home for services but I have my own beliefs so I just keep them to myself." A staff member informed us, "I have books on all faiths. We used to have a gentleman that when he wanted to pray I'd help him put his hat on to pray in bed." A new multi faith room was in the process of being developed within one of the buildings.

We saw posters related to events that had taken place and were upcoming including a summer fete and pet therapy, A whiteboard was updated to clearly display weekly activities. Staff spoke to people about their interests and upcoming events, we saw that staff talked about a person's favourite film with them and they began singing songs from its soundtrack together. The staff also asked two people about whether they were looking forward to the 'Western' event that they were attending the following day. One relative told us, "My spouse enjoys the sensory room and sits and relaxes in there, it is very calming for us both." Another relative said, "The activities are second to none in the home."

People's relationships were encouraged through group activities and the service made efforts to integrate the separate units through the 'Battle of the Units Quiz.' People were encouraged to partake in community activities independently where appropriate. One person told us, "I go out a couple of times a week for coffee as I like lattes." During the inspection we saw people attended local day centres. One person told us, "I can't get out on my own because it's hard being practically bed ridden but I have been out twice in 3 months into

the town. They need to use the hoist to get me out of bed and into a suitable chair and I've had no problems."

People told us there was a monthly meeting for everyone who lived at the home. The meetings looked at how people had enjoyed past events, improvements they'd like to see and they gave people an opportunity to raise concerns or issues they may have had. For example, people had raised that they had not enjoyed a chicken pie option on the menu, but preferred steak and kitchen staff were happy to make adaptations to menus to meet people's preferences. We saw handwritten minutes from these meetings. We did not see evidence of the minutes being made more accessible to receive or give feedback to people less able to attend or contribute to these meetings however, the service had taken some other steps to ensure people had some accessible information such as with a pictorial complaints procedure.
People told us they knew how to complain if they needed to. One person said, "I've got nothing to complain about but if I did you can bring it up at the residents meeting or speak to the management." A relative told us, "We know how to complain and did a few days ago. What is important is how it is managed and full marks to all the team for dealing with it in a courageous way. It was impressive." Records showed that complaints received had been managed appropriately and their outcomes documented.

Where appropriate people had plans in place relating to their end of life wishes and were recorded in care plans and reviewed monthly. At the time of our visit no one was receiving end of life care. Staff received training in providing end of life care to people. Some details related to people's end life wishes had been captured such as details of who to contact should the situation arise. However, some end of life care plans would benefit from additional information. For example, for one person we were unable to identify which religious service they would like to use or relevant contact details for this service in the event of their death. Further detail would mean all information was available to inform staff of the person's wishes at this important time to ensure people's final wishes were respected.

The provider had given consideration as to how to support people receiving end of life care and their loved ones. They provided personalised memory boxes for people when they moved into the service which could be used to keep peoples personal possessions such as rings and photos. Families could take the box away with them following the person passing away. The service had also developed a 'compassion pack' for families containing items they may need if staying over to be with people close to the end of life. The pack contained practical items such as toothbrushes. Following a person's death families were provided with an appropriate bag to pack belongings into. The bag also contained a 'with sympathy' leaflet to help ease families distress when the persons belongings left the home. Families were also provided with relevant information including support services for those bereaved. Staff held fundraisers to raise money for garden memorials, such as a bench or rose, for those who had passed away.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. The registered manager was absent during this inspection and the service was being managed by the deputy manager and two of the provider's representatives.

Governance processes were not robust and had not identified many of the wide range of issues we found during this inspection. Medicines audits had not highlighted the shortfalls related to 'as required', topical and patch administrated medicines or medicines records. We found a breach relating to the safe care and treatment of people relating to this. Care records audits did not identify issues relating to mental capacity records. Whilst several audits and checks were carried out we saw these did not always drive improvement.

Audits undertaken by the provider and management team covered areas such as the environment, staffing and health and safety. Care plans, kitchen and domestic audits were also undertaken and the registered manager had carried out a weekly audit to identify issues and requirements.

People told us the management team were approachable and a visible presence in the home. One person said, "I do know who the manager is and I would say they are friendly and always listen to you." Another person said, "I get the impression that they listen when I speak." A relative said, "Yes, it's got a really nice atmosphere, it's kept clean and tidy and the staff are always nice to everyone."

We received mixed feedback from staff about the support they received from the management team. One staff member said, "Morale is a bit low." Another said, "It's heading back in the right direction." The provider told us that they were aware that some internal events had resulted in low morale for some staff but that they were taking action to address this including through their visible presence within the service.

Meetings took place for relatives and people living at the service. One person told us, "I've been to quite a few of the resident meetings and we discuss our care and meals and things like that." Feedback was sought from people and their relatives through surveys and informal chats.

Meetings for staff were held at regular intervals. Minutes were maintained and made available to staff. These detailed the matters discussed, actions that needed to be taken and by whom. A staff member told us, "Things raised in staff meetings will be responded to appropriately and actioned."

The service was partnership working with other health and social care agencies to meet people's needs. Records showed that where advice had been given by external agencies the new management team had ensured the advice was followed. There was evidence of the service working in partnership with others such as social workers and health professionals. Links with the community were well maintained through events and fetes as well as people accessing services in the community.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service in the form of a 'notification'. The management team had informed CQC of significant events in a timely way by submitting the required notifications. This meant we could check that

appropriate action had been taken.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people. The provider had failed to ensure the proper and safe management of medicines. Regulation 12 (1) (2g)