Meridian Healthcare Limited

April Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 17 and 19 May 2017, the first day was unannounced. The service was last inspected in May 2016, when it was found to require improvement in all areas. We found that the service still required improvement at this inspection.

The service is a residential service registered to provide personal care for 40 people; on the days of inspection there were 36 people living there and two people were attending for respite care but lived in their own homes. The service does not provide nursing care.

There was a registered manager in post and they were present for the first day of 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.

People were not always safe at April Park Nursing Home. We found accidents and incidents were not always recorded or investigated thoroughly and staff were not always informed of how best to care for people. There were inconsistencies in how people with limited mobility, were supported to mobilise or transfer safely by staff. Risk assessments were not always updated following incidents and care practice was not always changed to reduce the risk of reoccurrence.

Not all staff understood how to report safeguarding concerns, outside of the organisation. The provider was unable to produce all the relevant documents relating to staff recruitment and could not assure us that all staff working at the service had been thoroughly checked before they started caring for people. There was not always sufficient staff available to care for people, especially at busy times.

Medicines were managed safely and people received their medicines as prescribed.

Tools and processes available to monitor people's health were not used effectively, which meant it was not always possible to identify when people were at risk of dehydration or at nutritional risk. Training was not always up-to-date and we saw the impact of this on how some staff supported people with limited mobility. Staff did not always follow the advice from specialist healthcare practitioners.

Staff did not always engage with people when decisions had been made about their care. Staff were task focused and peoples care was not always personalised. People and relatives did not feel consulted by the service or the provider and said changes were made to people's care or the service, without any involvement of the people it affected. Relatives were welcomed into the home when they were visiting.

The service did not always respond positively, or constructively, to comments and complaints. Families were unhappy with the lack of response to their comments or complaints and felt the management team did not

listen to them.

The tools and systems in place to monitor the effectiveness of the service, had not always been used effectively. They had not always identified areas for development and had not always led to improved care of people. Information they were required to share with us and other authorities, was not always shared in a timely manner.

Staff were supportive of each other and full of praise for the management team.

At this inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

Incidents, accidents and risk assessments were not always reported accurately which meant staff did not always know how to prevent further incidents or harm to people. Not all staff understood how to report safeguarding concerns, outside of the organisation. There was not always sufficient staff available to care for people. Medicines were managed safely and staff received relevant training.

Is the service effective?

Requires Improvement

The service was not effective.

Training was not up-to-date and information regarding incidents was not always shared with staff in a timely manner. Tools and processes to monitor people's health were not used effectively. Staff did not always know when people's needs had changed. Advice from healthcare professionals about people's food and fluid was not always followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives were not always involved in their care planning. Staff usually cared for people with kindness and compassion. However during busy times, staff became task focused and were not as caring or considerate to people. We saw warm and friendly interactions between people and staff.

Is the service responsive?

Requires Improvement

The service was not responsive.

Staff did not always understand people's lifestyles and histories and were not always able provide a personalised response to people. People and families were not always consulted about their care or any plans for service development. Complaints were not well managed. People and their families did not always get a timely response to their concerns or complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Information was not always sent to the relevant authorities, in a timely manner. The quality assurance systems in place did not always identify where improvements were required. Systems and processes designed to ensure quality and safety of the service were not always effective. A new registered manager had been appointed since the last inspection.

April Park Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

This inspection took place on 17 and 19 May 2017 at April Park Nursing Home, the first day was unannounced. The inspection team consisted of an inspector, an inspection manager, a specialist professional advisor, and an expert-by-experience. The expert-by-experience had personal experience of caring for an older person. The advisor was a nurse with experience of caring for older people.

The registered manager was present on day one of the inspection along with a regional manager from the provider and the deputy manager from April Park. The regional manager and deputy manager were both present for day two of the inspection on 19 May 2017.

Before the inspection we reviewed any information we held about the service, including any information the provider had sent us. This included the provider information return (PIR) which they had returned to us. A PIR is a report that we ask the provider to complete which gives details of how they deliver their service, including numbers of staff and people using the service, and any plans for development. We also reviewed any notifications the provider had sent us. Notifications are reports the provider must send to us to tell us of any significant incidents or events that have occurred.

We spoke with eight people who used the service and five relatives. We also spoke with eight staff members, including the registered manager, area manager and deputy manager. We reviewed eight records associated with people's care, including medicine administration records. We also reviewed records associated with the management of the service, including staff recruitment and training records, policies, and development plans.

During the inspection the broadband and internet service was not always available and we were told this had been the situation for the previous five weeks. The registered manager told us, this had made it difficult for them to access the provider's quality assurance system, 'Cornerstone' and associated databases; as well

as send or receive emails. It also meant some information we requested was not available during the inspection, but this was sent to us at a later date.

Requires Improvement

Is the service safe?

Our findings

People felt safe at April Park but staff needed further information relating to external organisations on how to report any concerns they may have. One person told us, "I do feel safe here and think the staff know what they are doing"; and relatives told us they felt their loved ones were safe at April Park. Staff received training on how to protect people from the risk of abuse or harm and there were policies and procedures in place to support them, if they had any concerns. Staff understood the signs and symptoms of abuse and were able to tell us how they would report any safeguarding concerns, within the organisation. Although we had received whistle-blowing concerns before the inspection, we found not all staff were clear how to report safeguarding concerns, outside of the organisation. We saw a whistle-blowing poster in the lift and there was a safeguarding adult's poster in the staff room, which contained relevant phone numbers for staff to report any concerns. However, we did not see any posters advising visitors how to raise safeguarding concerns. This meant information on how to safeguard people from harm or abuse was not promoted or easily available to people, staff or visitors.

Accidents and incidents were not accurately recorded. They did not always lead to a review of risk assessments, which would help staff prevent similar incidents from occurring again. For example, we found no updated risk assessment or review of care following an incident when one person fell from a hoist. The investigation that took place after the incident was inadequate; and there was no action plan which would help staff prevent a similar incident occurring again. Another person's relative said they regularly arrived to find the call bell on the floor and out-of-reach of the person, they said this person had been identified as a falls risk. We saw that one or two people wore a call bell pendant around their neck, but staff said not everyone wanted to wear them. Staff did not always ensure people were safe when they were alone and did not always promote the safety tools that were available to keep people safe.

One person told us, "I have to be hoisted and I hate it, it's horrible and it catches my leg sometimes. But I can't walk any longer so I don't have any option". We also observed two people sitting on hoist slings in armchairs in the lounge. When we checked their records we found there was no risk assessment for this and this practice had not been recommended as part of their care plans.

People were not consistently protected from risks associated with their health conditions. Records identified when people had lost weight, but this information had not always led to reviews of care plans or risk assessments. We found that people's hydration had not always been recorded accurately or monitored. This meant it was not always possible to identify people who were at risk of dehydration and associated health conditions. Risks to people were not always identified which meant action could not be taken to reduce the risk of harm to people.

There was not always sufficient staff available to care for people, especially at busy times. The registered manager used a dependency tool to calculate how many staff were required to meet people's needs. We found generally there were sufficient staff to care for people and people told us staff responded 'efficiently' to their call bells. However, we found during busy meal times there was not enough staff to provide the assistance people needed, or to ensure people received their meals on time. For instance, we observed a

lunch time service in the downstairs dining room where people were left waiting for over 35 minutes before their food arrived; and people who required assistance to eat, waited much longer. We also saw that, although there was a staff presence in the communal lounge areas when people were in there; staff were focused on their tasks, for example, updating care records or providing activities. They were not always alert to the needs of people in the room. This demonstrated that staff were not always deployed effectively, to ensure that people's needs were met in a timely manner.

We checked staff records and noted that all staff had provided two references and a disclosure and barring check (DBS). This demonstrated the provider had ensured potential staff were safe to care for people. However, not all staff records included a contract of employment, a copy of the application form or a declaration of fitness to work. The deputy manager told us these records were stored centrally, but they did not forwarded copies of these to us. This meant we could not be assured that they have been completed correctly with all the relevant information regarding staffs previous employment, training and fitness for work. We did not see evidence to demonstrate the provider had followed safe recruitment practice, when employing staff to work at the service and to care for people.

Medicines were managed safely. One person told us, "Yes, they manage my medication fine…they give it to me and wait until I have taken it, then move on". We observed medicines being administered to people and saw that good practice was followed. We saw, appropriate recording and storage of medicines; procedures were in place for the receipt and disposal of medicines; and staff checked people were given their medicines as prescribed. Staff who administered medicines received the required level of training from the pharmacy who supplied the medicines; and were checked for competency at the end of the training by the pharmacist and the registered manager. Where people self-administered their medicines we saw information was available to them to ensure it was administered safely and in accordance with how it had been prescribed. This was checked by the staff trained to administer medicines. There were suitable processes in place to ensure medicines were administered and managed safely.

Requires Improvement

Is the service effective?

Our findings

One relative told us, "The carers are fantastic, but they do not get the communication to tell them how to care for people… they respond when you say something but it shouldn't have to get to that stage". Another relative told us, "Some care staff are brilliant, but others need more training and direction".

The provider expected new staff to complete the organisation's own induction programme, which included online learning, face-to-face learning and observations. Staff had on-going access to online training and were given time-frames for completion of required training. Completion of this was monitored by the provider. This showed the provider recognised the need to ensure staff had the necessary training and skills to meet people's needs. Staff told us they found the training useful but not as effective as face-to-face training where they could discuss ideas and real-life incidents.

We saw the training matrix and saw most of the training required by the provider was up-to-date or planned. However, we found that only 60% of staff were up-to-date with training to ensure people were supported to move about safely. We also observed inconsistencies in how people were assisted to mobilise by different staff. If the most appropriate assistance was not agreed for individual people and followed by all staff, people could be at risk of falls or injury. We also saw one person assisted to stand on two separate occasions, by two different staff, one staff member used a standing aid and encouraged the person to pull themselves up whilst another member of staff 'held on' to the person and assisted them to stand. This demonstrated that the training in place was not effective at developing a consistent approach to the safe moving of people.

Staff were supported by regular supervision and support meetings with their line manager. There was a staff supervision policy in place which stated that staff had a combination of one-to-one and group supervision throughout the year. We saw the supervision matrix and saw that most staff had received regular supervision. Staff told us they found supervision to be "useful and a good opportunity to discuss things". We saw evidence that group supervision had taken place after the first day of our inspection, to address some of the concerns we had raised regarding the ineffective use of tools to monitor people's hydration levels. Staff told us they had found this useful and expectations were much clearer. Although staff were supervised and supported, this had not always led to consistent and effective practice and good care of people.

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 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. We found the provider had identified

people who received restrictive care that amounted to a deprivation of their liberty, and had applied for DoLS. However, we found in some cases where DoLS had not yet been authorised; decisions and safety measures had been put in place, without recording any 'best interest' discussions or agreements. For example, we saw some people had sensor mats or bed rails in place in their bedrooms, when there had been no prior discussion with people or their families. Staff we spoke with were unclear which people had a DoLS in place, which people were waiting for authorisation and what a DoLS would mean for how people were cared for. This showed that although the provider took responsibility to ensure that they were operating under the principles of the MCA and were not placing unlawful restrictions on people; staff required further training and understanding of the MCA and how DoLS were applied and how they impacted on the care people received.

People were not supported to have enough to eat and drink. We found there were processes in place to record what people ate and drank, as well as record their weight. However, these records were not always completely accurately and were not used to monitor people's nutrition or hydration. Therefore staff were not able to identify any associated risks to people from weight loss, de-hydration or poor nutrition. For example we found one person had lost weight, but their food and drink had not been effectively monitored to ensure that they were sufficiently hydrated. This person had also experienced an increase in the number of falls and there had been no analysis to see if this was related to their weight loss or their reduced nutrition and hydration. This demonstrated that some people were at risk from preventable deterioration in their health, if their basic needs for food and drink were not met or monitored.

We spoke with the cook who explained how they developed menus around people's dietary needs and preferences. They said they took advice from dieticians and speech and language therapists (SALT) regarding the correct content and consistency of people's food. However, one person told us, "I don't think she whizzed it up today like she normally does - but I've managed it… I often have it liquidised but not today. I have tonic water to help me swallow it"; when we checked this persons records we saw the advice from SALT was for 'fork mashable food'. We did not consider roast pork to be 'fork mashable' and felt this person had been put at risk of choking as dietary advice had not been followed on this occasion. A relative told us their family member had been recommended to eat 'fortified and thickened' food, but they told us they had to bring in their own yoghurts and drinks for their family member, as they were often left in their room with biscuits which they could not eat or drinks out of reach. Staff did not always follow advice from specialist teams and people were at risk from poor nutrition management and poor care at meal times.

The meal time service we observed was not efficient as people were left waiting in the dining room for over 35 minutes with no explanation. We overheard comments from people waiting for their meal such as, "Will something be wrong in the kitchen?" and "It's always pretty late down here, it would be nice to be first for a change" and, "It's never early down here". When the meal did arrive, staff were leaving the dining room to take meals to people in their own rooms, before everyone in the room had been given their meals. People were given a choice of two meals, either pork dinner or chicken pasta. However, if people chose the pork option, their meals were plated up with full vegetables, gravy and black pudding, without asking people what they would prefer. There was a plated meal to show people who could not decide which option to choose, but we did not see this being used by staff when offering the choice. We saw staff repeatedly shout to people across the room or the table, in an undignified manner, "Do you want pork or pasta". The arrangements for the lunchtime service were not efficient, effective or sociable. There was little engagement between staff and people waiting for their lunch, and no music or activity to keep people occupied whilst they waited.

People were supported to maintain good health and access relevant healthcare services. One person told us "The doctor comes every week…and you can see them if you want to". We saw one person's family came to

take them to a dental appointment during our inspection, we saw they updated staff with details of the treatment this person had received when they returned from the dental appointment and staff updated their records. We saw records that demonstrated people were referred for specialist health support when required; including chiropody, optical and dental care. We observed a telephone call a staff member made to the GP, informing them of blood sugar trends and insulin levels, this demonstrated they had a good knowledge of the person's care needs. People told us they received visits from health practitioners at the home, or they were supported to access healthcare in the community when required.

Requires Improvement

Is the service caring?

Our findings

People or their families were not always directly involved when their care was reviewed each month. There was detailed information in people's care plans about their care needs when they were admitted to the service. However, we found little evidence of this having continued throughout a person's stay in the home. Although care plans were reviewed each month, this was usually done by the care staff and did not include input from people or their families. A staff member told us, "We know what's happened so we just do it ourselves". One person told us, "I know they have to write about me but I didn't know it was called a care plan". Relatives told us they were involved and consulted when their loved ones, first came to the home, but less so after first moving to the home. Two relatives told us they had not been consulted about a review of their family member's health care needs, which may ultimately lead to them having to move to a home that is able to meet their increasing needs. This demonstrated that staff did not always engage with people when they were making decisions or reviewing their on-going care needs.

Relatives visiting a family member told us, "Staff are so focussed on their specific tasks…. they don't see it as their 'job' to do the other little things - like watering flowers, that would make such a huge difference, which is a shame." Although we saw examples of staff speaking respectfully to people, using their preferred names and using caring and engaging body language; we found that at busy times staff became pre-occupied with the tasks to be completed rather than on people and their individual needs. For example, we saw staff sat in the lounge where people were seated during the day, but they were not sat chatting with people or watching over them, they were busy filling in care plans or other records. During this time, one person was becoming restless and agitated. Staff did not fully engage with this person when they clearly wanted some conversation or meaningful activity, they were more focused on the completion of tasks. This demonstrated a lack of respect for people and their needs.

At lunchtime people were left waiting for their meal in the downstairs dining room for 35 minutes, with no explanation or engagement from the staff present in the room. When food arrived it was served in a disorganised manner, with staff taking plated-up meals to people in their own rooms before ensuring that all people sat in the dining room had received their meals first. People were left eating in the dining room without a staff presence and people who required assistance to eat were left until last. One person was assisted to eat by a staff member who stood by their side and spooned food into their mouth, without any comment or attempt at communication. The staff member was looking around the room and did not attempt to engage with the person or anyone else. This demonstrated a clear lack of dignity or respect for people. The provider had a 'dining with dignity' policy in place that all staff should follow to ensure people had a dignified, sociable and enjoyable dining experience. On this occasion staff did not follow this policy and people were not treated with respect or dignity.

However, people told us they received care from staff who were friendly and treated them with kindness. One person said, "It's lovely. I like it here"; and another person showed their manicured nails to their friends; they said, "It's a treat for a woman to be asked what colour do you want… it matches my jumper". One person who visits for respite care a couple of days each week, told us, "I like it, they're very pleasant people... my daughter knows I'm looked after and I get a decent meal… I know most of them by now and they know

me". This persons relative was full of praise for the care their loved one received and told us, "They are not only there for mum, but they are there for me too, they put me right and give me support and advice when a need it… they are marvellous… the staff are amazing, they just go the extra mile". Another relative told us, "They always make me feel welcome; we are always offered a drink and cake when we visit in the afternoon". One staff member told us how much they enjoyed caring for people and said, "I'd do anything for them". We saw staff using people's preferred names and we saw warm and friendly interactions between them.

People were given choices and options regarding their daily living arrangements. Staff provided examples of how people were given choice, for example: people chose when to go to bed and get up and they could choose either to take part or not in activities. We saw people were given a choice of meals, snacks and drinks throughout the day. People told us they chose what to wear and we saw people were dressed according to their preferences which were documented in their care plan. We saw people were smartly dressed, some ladies wore jewellery or make-up and carried handbags; men were shaved and well groomed. Staff were able to tell us what people preferred to wear and how they liked their hair to be done which demonstrated that staff had a good understanding of people's preferences and respected these, promoting people's individuality and dignity. We saw some people remained in their own rooms all day including meal times, and they told us this was their choice. People made decisions about their daily living arrangements which gave them some independence and control.

Staff were aware of people's rights to confidentiality. We saw records were stored safely in lockable cabinets in the care staff office; where phone calls to GP's also took place in private. Private rooms were available for staff to meet with people and families, to discuss confidential issues; and for visitors to meet with people away from their bedrooms. One person told us they preferred female staff to care for them and we saw this was documented in their care records and we saw female staff caring for them throughout the day.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive to people's individual needs. Relatives visiting a family member told us "We have stopped bringing flowers now because time and time again we have brought them, and by the time we come back a couple of days later there has been no water in the vase – and the flowers have just shrivelled up and died. This has happened so many times now, we have just given up. You see it's the little things like that, just making sure that there's fresh water topped up in the vase, which makes the world of difference".

Another relative told us they often arrived to find drinks or food left out of reach of their family member, who was identified as at risk of poor nutrition and hydration. They told us, "How is she able to eat and drink if they leave it out of reach and don't sit with her to make sure she has eaten". Staff did not always provide care that was personalised to individual needs.

We saw one person showing signs of agitation and restlessness for 90 minutes in the lounge whilst staff were present. This person asked staff a number of times, "What are you doing?" and, "Can I help?" Staff either ignored them or made brief responses but did not look up from their writing or move to sit with this person, to calm them. This person said to another member of staff who was sat leaning on the arm of a chair looking around the room, "You don't look very comfortable, why don't you sit down properly", the staff member replied, "Naa, I'm OK here" and continued to look around the room. A staff member later told us, this person, "Often behaves like that and I just offer them a cup of tea and it calms them down". When we asked if they knew what this persons previous occupation or routine had been, or if they had any particular interests that would occupy them, the staff member did not know. This demonstrated that staff did not always have the skills or knowledge to respond to people or engage with them on a personal level, when they were becoming agitated or restless.

Staff did not respond to people's questions and comments, whilst they were sat for 35 minutes waiting for their lunch. The staff present did not attempt to engage people in conversation or activity; and from the comments made by people, it appeared that meals were frequently served late. This was further evidence of a poor response to people's individual needs.

Staff did not always know about people's past lives, interests and aspirations. There were tools and processes in place to capture details of people's past lives, interests, and aspirations; as well as people, places and events, that were important to them. However, we found where these had been completed; they contained only basic information and were not used effectively by staff, to build their knowledge and understanding of individual people, in order to provide a person-centred service. We saw little evidence of people's religious preferences being known or promoted. One person told us they liked to go to church, but were unable to go now because of their mobility. We asked staff if they supported people to attend their place of worship, or maintain their connection with their chosen faith. One staff member said, "One person has visitors from the church and they come and read the bible". When we asked for any other examples they replied with shrug, "Sometimes we sing hymns". This staff member was not aware of any other people who liked to go to church. Staff were not always able to offer a person-centred service to people as they did not

have an understanding of people's personal histories.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) person centred care 2014.

The service did not always respond positively to concerns and complaints. Two relatives of a person living at the home, felt they were considered to be a nuisance by the management team, because they had complained about the care their loved one had received. We found the provider had not followed their own complaints policy in response to this complaint and they were unable to give us a satisfactory response when we asked for the reason for this.

Another relative told us they were not happy with the response they got to complaints or concerns they raised with staff, about cleanliness and personal hygiene. They told us, "Eventually the manager became involved and she sorted it, but you shouldn't have to get to that stage." We found no evidence of this complaint in the complaints records and staff told us "We just sort it when they tell us; things don't always have to become a full blown complaint". There were no other complaints recorded and the registered manager told us they had not received any other complaints.

The results of the last family survey dated June 2016, identified 40% of people or relatives were unaware of the complaints policy; and 11% of those who had complained felt the response from the provider was inadequate. The provider response stated they had placed a copy of the complaints policy in the reception area and decreased the response time from 28 days to 14 days. However, when we asked for a copy of the complaints policy that was given to people and their relatives, staff were unable to produce one. We found there was a lack of understanding of how to identify complaints, how to learn from them and how to use them to inform continuous improvement of the service and the care people received.

There were processes in place to enable the management team and provider to capture feedback from people and families; however these were not promoted or used effectively. The provider information return (PIR) stated that meetings with people and their families took place each month, but we could find no evidence to support this and there were no minutes from any previous meetings available. Relatives told us meetings were stopped by the previous manager, as they did not want to listen to where they were not doing so well. Relatives said these meetings had not been re-instated with the new registered manager. We saw a brief impromptu 'residents meeting' taking place after an activity on day one of the inspection. However, this meeting was unplanned and people told us they were not expecting it. The only discussion was about choices for upcoming trips. People and relatives were not consistently consulted on the quality of care, and the provider did not always respond positively to improve the service.

There was a programme of activities each week, and we were told this was flexible to meet the changing needs and preferences of people. We spoke to the activities worker who told us what activities were available and showed us the records they kept of activities and events that had taken place. We saw photographs of people enjoying activities and evidence of creative work was on display. People told us they really enjoyed the gardening activity; and in the garden we saw wellington boots that people had 'potted-up' with flowers the previous week. There was a mixture of group and one-to-one activities or outings, to suit people's individual needs. We saw bingo, a word game and flower arranging taking place during our inspection. One person enjoyed knitting and was sat in the lounge, knitting alongside other people who were flower arranging. This was a friendly chatty time for those who joined in. People had access to a variety of activities that was developed around their personal interests.

Requires Improvement

Is the service well-led?

Our findings

It was clear throughout our inspection that staff had good relationships with people and appeared to be confident and motivated by their role and responsibilities. However, there was work required to ensure all staff were supported and guided by an effective management team; and all staff had the necessary skills, knowledge and attitude to ensure people received good quality care and were cared for with dignity and respect. Although the staff team worked well together and supported each other, this had not necessarily led to improved care for all people who used the service. There was more support required from the provider to ensure that areas for development were identified; and resources were focused on driving forward the improvements necessary, to ensure good quality care of people using the service.

The registered manager had completed and returned the provider information report (PIR) to us, prior to the inspection. Information in the PIR did not reflect our findings during the inspection. For example, the PIR stated that there had been three complaints in the previous 12 months, yet staff could only provide evidence of one complaint; and the PIR stated that staff recorded and analysed all accidents, incidents and near misses, yet we found some incidents had not been recorded and investigations had either not taken place or were incomplete and ineffective. The monitoring and reporting systems in place were not used effectively to identify areas for development and had not led to improvements in people's care.

There was a positive and constructive response to the concerns we had raised on the first day of inspection. Before we returned for the second day of inspection, the provider had arranged for a 'rapid response team' to visit the service, audit records and address some of the concerns we had raised. An action plan had been developed and we saw evidence that some points had already been addressed. For example, group staff supervisions had taken place; and care records had been audited. This demonstrated that the systems in place had not always been used effectively to improve the service prior to the inspection; or to support the new registered manager and deputy.

The quality assurance systems in place were not used effectively. Whilst these systems had the potential to identify and drive improvement in services, they had not been used effectively, to bring about the improvements identified as being required, at the last inspection of April Park Nursing Home in May 2016. Some of which, still required improvement at this inspection. For example we found that incidents were still not accurately reported or investigated; they were not following their own complaints policy, and people and families were still not adequately consulted about changes in their care, or the way the service was developed.

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

There had been a change in registered manager since the last inspection. The current registered manager had been in post for five months. Staff said they felt supported by the registered manager and felt the introduction of the deputy manager role had a positive impact on how they all worked together. When we asked staff what they were most proud of they repeatedly told us, "the team" and "teamwork". Staff told us

the registered manager was "approachable" and "supportive". One staff member said, "She's brilliant, we couldn't ask for a better manager". The registered manager told us they held 'flash' meetings every day with senior staff to keep up-to-date with the service and what was happening. Staff said they appreciated the fact that the registered manager was visible and available to offer support and guidance where needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure people who used the service received person centred care that was appropriate and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured effective quality assurance and governance systems were in place to recognise and make any required improvements at the service.