Villa Care Limited

Park Lodge

Inspection report

10 Park Avenue
Roundhay
Leeds
West Yorkshire
LS8 2JH

Tel: 01132659353

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16 August 2018

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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

This comprehensive inspection took place on 30 July, 1, 3, 6 and 16 August 2018. On 30 July and 6 August 2018, the inspection visits were unannounced. On 1 August 2018, we made telephone calls to people who used the service and their relatives. On 3 August 2018, we made telephone calls to staff. On 16 August 2018, the inspection visit was announced.

Park Lodge operates both a care home and domiciliary care service under the registration of this location with the Care Quality Commission (CQC). The care home provides accommodation for persons who require nursing or personal care for up to 40, primarily, older people. The domiciliary care service offers care to people in their own homes. At the time of our inspection, 38 people were using the care home service and 13 were using the domiciliary care service.

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

This service is also a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and younger disabled adults.

Park Lodge was last inspected on 10 November 2015 and the service was rated as Good. On this inspection, the service has been rated as Requires Improvement. Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive; we found systems in place to ensure improvements were made and sustained were not effective. This is the first time the service has been rated Requires Improvement.

There was a registered manager in post. A registered manager is a person who has registered with CQC 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.

There were systems in place to monitor and improve the quality of the service provided. However, these were not fully effective and had failed to identify the concerns we found with regards to several records in the service.

We found some care plans lacked person-centred detail and contained inconsistent or contradictory information. This could lead to people's care needs being missed or overlooked.

We identified some improvements were needed to the records of medicines administration. The registered manager acted to ensure the concerns were addressed by the end of the inspection.

Overall, we saw risks were managed, and staff understood how to ensure these risks were minimised. However, records of risk management needed to be strengthened.

The registered manager and staff we spoke with had some understanding of the principles of the Mental Capacity Act (MCA) 2005 and their responsibilities when working in accordance with the legislation. However, where people lacked capacity to make decisions about aspects of their care, records did not show how decisions had been made in people's best interests.

We recommend the provider reviews the records of capacity assessments and decisions made in people's best interests to ensure people's rights are fully upheld.

Staff were seen to be kind and caring in their interactions with people, but some people told us they did not always find all staff to be caring in their approach. Staff showed a good knowledge of the people they supported, and understood how to maintain their privacy and dignity.

People and staff told us the service was safe. Staff could tell us how they would report and recognise signs of abuse and had received training in safeguarding adults. Recruitment was managed safely.

There were enough staff to provide support and ensure people's needs were met. Staff received supervision, appraisal and training to enable them to carry out their role. Staff spoke highly of the support and training they received.

People received support from health care professionals where they needed this to keep well. People spoke highly of the food at the service and their dietary needs were recognised and met.

There were effective systems in place for responding to people's concerns and complaints. People told us they knew how to raise concerns if they had any.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this 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.

Records we looked at did not indicate medicines were always managed safely. Records of risk management needed to be strengthened.

Staffing levels ensured peoples care and support needs were met.

Recruitment was managed safely.

Is the service effective?

Requires Improvement

The service was not fully effective.

People's rights were not fully protected under the Mental Capacity Act. Records did not show how decisions had been made in people's best interests.

Staff were trained and supervised to care for people effectively.

People received the support they needed to maintain their nutrition and hydration, and ensure their health needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people told us they did not always find all staff to be caring in their approach.

Our observations showed people were supported by kind, caring staff who respected their privacy and dignity.

People's equality, diversity and human rights needs were met.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not always sufficiently detailed to guide staff to provide their individual care needs in a consistent way. However, staff were familiar with people's preferences and needs.

There were a variety of activities available to people.

There was a system in place for handling complaints. People knew how to use the complaints procedures.

Is the service well-led?

Requires Improvement

The service was not consistently well- led.

A programme of quality audits was in place but had not been effective in highlighting the issues we found with records at this inspection so action could be taken.

Staff were supported by the registered manager and felt able to have open and transparent discussions with them.

People who used the service and their relatives were asked for their views about the care and support the service offered.

Park Lodge

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.

Inspection site visit activity started on 30 July 2018 and ended on 16 August 2018. It included visits to the location and telephone calls to people who used the service, relatives and staff. Days one and two of visits to the location were unannounced; the third day visit was announced.

On day one, two adult social care inspectors and an expert-by-experience carried out the inspection visit. On day two, an expert-by-experience made telephone calls to people who used the domiciliary service and their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day three, an adult social care inspector made telephone calls to staff from the domiciliary care service. On day four, two adult social care inspectors and an inspection manager carried out the inspection visit. On day five, an adult social care inspector and an inspection manager carried out the inspection visit.

Before the inspection, we reviewed all the information we held about the service including statutory notifications. Statutory notifications, which are a legal requirement, provide the Care Quality Commission (CQC) with information about changes, events or incidents so we have an overview of what is happening at the service. We contacted relevant agencies such as the local authority and clinical commissioning groups, safeguarding and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider had completed a Provider Information Return (PIR) in February 2018. We used 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 some key information about the service, what the service does well and improvements they plan to make.

During the visits we looked around the service, spent time in communal areas and observed how people

were cared for. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. During the inspection of both the care home and domiciliary care service, we spoke with nine people who used the service and 12 relatives. We spoke with eight members of staff, the advanced care practitioner, deputy manager, registered manager and director.

We spent time looking at documents and records that related to people's care and the management of the service. We looked at eight people's care plans and nine people's medicines records.

Requires Improvement

Is the service safe?

Our findings

We looked at medicine administration records (MARs), which showed most medicines had been administered as prescribed. We did however, find some records of administration needed to be improved. These included the application of creams, and the administration of low level pain relief and time specific medicines.

We saw arrangements for the administration of medicines for one person who used the domiciliary care service were not clear. Records did not fully demonstrate whether it was staff or a relative who administered medicines. The advanced care practitioner agreed to review the records to ensure this was made clear. We found two medication protocols had been completed for 'when required' (PRN) pain relief medicine; the reasons for administration were recorded as 'pain'. This was vague and did not specifically instruct staff on what area of pain the person may be in, nor did it advise when the person may need to be offered this pain relief medication. This person was prescribed a PRN laxative. There was no protocol or guidance for staff on the use of this medicine. During the inspection protocols were developed; however, guidance on when to give PRN medicines remained unclear. We found five people had been prescribed and administered paracetamol, as PRN, but there were no records to show what times these had been administered.

In the care home, medicines were stored in a lockable cupboard and stock checks were completed. Some people living in the care home were prescribed controlled drugs (CDs). We found controlled drugs had been administered and recorded correctly. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperature to avoid any adverse effects. Staff were trained in medicines management and their competency was assessed.

We found some risk assessments had been carried out to reduce risk. For example, one person who had fragile skin used a pressure relieving cushion to reduce the risk of skin damage. We found one person had been at risk after a skin infection was found; appropriate action was taken to treat them and ensure others were kept safe. Another person had a plan in place on how to ensure their skin integrity. This contained detailed information on positioning and use of creams and pressure relieving equipment. However, not all risk assessment records were robust as we found they were not always accurate.

One person at risk of falls had bed rails in place to prevent the risk of falling out of bed and the assessment stated the person should use their call bell when needed. However, another record stated they were unable to use the call bell. We saw another person's records noted they had been assessed as low dependency. One of the points qualifying for a low dependency scoring was that the person 'Walks without assistance but probably uses a stick/zimmer/tripod.' The same person's daily notes showed that they were hoisted and used a wheelchair. However, there was no risk assessment in place to guide staff as to how to move them safely in order to minimise the risk of them coming to any harm.

Staff could describe the risks people faced and what they did to prevent and manage risk. People and their relatives told us they or their family members were cared for safely. People's comments included; "I am fine; safe and well with the care workers", "Excellent relationship with my relative; she looks forward to seeing

them [staff]. She is always safe and comfortable with the care workers" and "Yes, I feel safe." Our observations showed us staff treated people well and all interactions we saw were positive. Staff demonstrated their understanding of safeguarding procedures to ensure people were protected from avoidable harm. Staff were aware of how to whistle-blow and there was a policy available for staff to use should this be required. Staff were confident any concerns reported would be acted upon by the management team.

The provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview, the provision of previous employer references, proof of identity and a check under the Disclosure and Barring Service (DBS). This service enabled the provider to check that candidates were suitable for employment with vulnerable people.

People in the care home told us there were enough staff to meet their needs. They said they never had to wait long for staff to attend to them and their requests for any assistance were responded to promptly. One person said, "The staff respond to the buzzer." Relatives of some people who used the domiciliary care service said they thought consistency and time-keeping of staff could be better. They said they had reported their concerns and this was an improving picture, overall. Records we looked at showed people received a service from consistent teams of staff and this was confirmed by staff we spoke with.

The care home premises were safe, clean and homely. Records showed checks of the building and equipment were carried out to ensure health and safety. This included fire evacuation practices and maintenance checks. People had personal emergency evacuation plans (PEEPS) in place. PEEPS provide information on an individual's safe evacuation from the premises in the event of an emergency. All the areas we observed were clean, including bathrooms and toilets. Staff had access to personal protective equipment throughout the home and wore this whenever appropriate to prevent the potential spread of any infection.

There were systems in place to ensure learning from any incidents or mistakes to ensure people were safe. Accidents and incidents were recorded. Any accidents or incidents were audited and analysed to identify what had happened and actions that could be taken in the future to reduce the risk of re-occurrence.

Requires Improvement

Is the service effective?

Our findings

People who used the service told us they made decisions about their care and treatment and were asked for their consent to any interventions. One person said, "I am always asked before they start moving me or washing me." Staff understood the need to gain consent before providing care and described how they would support people who may refuse care interventions. One staff member said, "I would always try to explain to people why I needed to help them but would respect people's wishes too."

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 MCA 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 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 authorisation procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found records did not show capacity assessments had always been carried out in line with the provider's policy and processes. We did not see records of best interest meetings or decision-making when people lacked capacity and decisions had been made in their best interests.

The provider had a capacity assessment form however, we saw no record of this being used in care records. We found staff had recorded when people lacked capacity to make certain decisions but there was no evidence to support how this decision was made. For example, the use of chair sensors or to have medicines administered covertly had no documentation to evidence these decisions were made in people's best interests and were the least restrictive options for them. We also saw there were contradictions in the records. One person's records showed they did not have the capacity to agree to their care yet in another part of the record it stated they did.

DoLS applications had been completed and submitted to the appropriate supervisory body and we saw evidence of these within people's care records. Some relatives had given consent on behalf of a person but it did not record if the appropriate legal authority was in place for them to do this. One person's record stated their relative had legal power of attorney however, we could not find documentation to confirm this. The registered manager told us they would not allow a relative to make any decisions about a person's care if they had not seen a copy of the legal power of attorney.

We recommend the provider reviews the records of capacity assessments and decisions made in people's best interests to ensure people's rights are fully upheld.

Overall, people told us their needs were met by trained staff who knew them well. Comments we received included; "All tasks are carried out with care" and "The care workers are wonderful; they do know what they are doing." However, one person told us some staff were not as good as others when moving and handling

them. Another person told us they thought staff rushed at times.

The environment of the care home was appropriate to meet people's needs and there was sufficient communal space available for people to be able to sit quietly or join in activities. Signage was in place to assist people to find their way around.

Staff told us they were well-supported and had received a good induction when they began their job to ensure they were confident in their role. They said they completed training and worked alongside experienced staff to get to know the needs of people who used the service. Records showed several training courses were completed in one day prior to staff commencing their role. This training day included moving and handling, health and safety, equality and diversity, basic life support and safeguarding adults from abuse. Staff then went on to complete the care certificate. The care certificate sets out common standards for social care staff. Training was refreshed at set intervals to ensure staff's skills remained up to date. Staff completed several specialist training courses to enhance their skills. These included; epilepsy awareness, falls prevention awareness, leg ulcer management, eye care and nutrition in adults.

There was a programme of staff supervision and appraisal in place. Supervision meetings are one to one meetings a staff member has with their supervisor. Staff told us they received supervision on a regular basis and they found this useful. It was not always clear how frequently staff received their supervision meetings as many records were not dated or signed by the person receiving or carrying out the supervision. Records of discussions were brief and any identified needs for staff did not have a support plan in place to show how they would be addressed.

People told us their day to day health needs were met and they had access to healthcare professionals when needed. We found health professionals attended the service to support people's needs and some of these included district nurses, tissue viability nurses, general practitioners and chiropodists. There was evidence of liaison and joint-working with health practitioners for people who used the domiciliary care service. We found people's weights had been recorded monthly and staff supported people with their dietary needs. One person living in the home had increased in weight. We saw evidence of staff supporting the person to reduce this so that their body mass index (BMI) was within a healthy range and over time this had been achieved. Care plans included nutritional need assessments and recorded people's preferences for food and drink so staff knew what people liked.

People had enough to eat and drink and maintained a well-balanced diet. Menus in the care home showed a variety of food was on offer and people's cultural dietary needs were catered for. People's comments on the food included; "The food is alright, the menu is brought the day before and I can choose what I want", "The chef goes the extra mile to cook what people like" and "Food is good. I get a choice but if I don't like the choices, they will make me something else." We saw mealtimes were a positive experience for people; those who needed assistance to eat and drink received this. People who used the domiciliary care service received the support they needed with eating and drinking. One person's relative told us staff supported their family member to eat the food they prepared.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback on whether people and their relatives thought staff were always caring. Overall, most people we spoke with said staff were kind and caring. People's comments included; "I would say they are caring; they do their best, they are kind and caring", "Yes, they are very nice to me; they smile, they listen to me. I am happy with them" and "The care workers are brilliant; they understand the culture, they try to speak to my relative in a way she understands. They are extremely caring." However, some people said they found some staff, "Grumpy" at times. Their comments included; "Largest percentage of care workers are good. There are the odd two that rush, want to get the job done, do not realise that my relative cannot communicate and therefore, should not be short with them. This really annoys me" and "Majority of care workers are wonderful; caring and compassionate. There are a few care workers who are very short, [mannered] have an attitude and lack compassion. They just want to get the job done and go."

We discussed some of these concerns with the registered manager who told us they were aware of some dissatisfaction from people who used the service and had tried to address this. There were no records of this in the complaints file. We did see there were minutes of a staff meeting where staff had been reminded of their approach and how they should communicate with people if their first language was not English. This showed the provider was aware of some of these issues and sought to remind staff of how to care for and support people appropriately. After the inspection, the registered manager provided further documentation on how a person's concerns had been addressed. Daily records indicated the registered manager had met with the person to discuss some of their anxieties and health needs.

We saw the provider had received positive feedback from people who used the service, relatives and health professionals regarding the caring nature of the staff team; both in the care home and the domiciliary care service. People's recorded comments included; 'Residents appear well cared for', 'continuity of care enables them to understand their patient's care needs', 'Thank you to the wonderful staff who have just started visiting [name of person], they have shown her nothing but kindness and considerate care' and 'I would like to thank everyone who looked after [name of person], you made life so much easier'.

Our observations showed staff understood people and supported them with dignity and compassion. Staff consistently spoke to people with kindness and always addressed them by their name. There was a calm and relaxed atmosphere and people had good relationships with staff. Comfortable interactions were observed with people and staff responded speedily to requests for any assistance. People looked well cared for; which was achieved through good standards of care. Staff knew people well and knew what was important to them. For example, family relationships and work history. Staff said this helped them get to know people better.

People were encouraged to make choices, and their independence was encouraged. One person said, "They [staff] let me do what I can; let me do things my way." Another person said, "I find the staff very encouraging where independence is concerned." Staff understood the importance of encouraging people to be as independent as possible. One staff member said, "It's important for people's dignity." Staff did not rush people and gave people time to make choices.

People's privacy and dignity were respected. We saw staff knocked on bathroom and bedroom doors and waited for a response before entering. People had no concerns about privacy and dignity. Comments we received included; "The staff respect my privacy" and "The staff treat me with respect. Staff always knock before they come in." People could choose whether to have their doors open or closed when spending time in their rooms and this was respected.

Some people told us they were consulted with and made decisions about their support. One person said, "I know bits about my care plan." However, others did not think they had this involvement. One person said, "Don't know if I have a care plan, we have never talked about it." Some relatives of people who used the service told us they did not feel involved in the planning of their family member's care. Our review of people's care records showed care plans were not always signed by people who used the service or their relatives to show they had been involved in planning care and support. We fed this back to the registered manager who said they would look into this matter with a view to making sure people felt more involved in the future.

The registered manager told us no-one who currently used the service received support from an advocate. They were aware of how to assist people to use this service if needed and told us information on advocacy was available in the service. An advocate supports people by speaking on their behalf, in their best interests, to enable them to have as much control as possible over their own lives.

Requires Improvement

Is the service responsive?

Our findings

Initial assessments were carried out to ensure people's needs could be met before moving into the care home or starting to use the domiciliary service. Assessments included the people who used the service, their family, if appropriate, and health and social care professionals.

We found some care plans lacked person-centred detail and contained inconsistent or contradictory information. Care plans did not always include details which would help staff to support people. For example, one care plan stated, "[Name] needs two staff to assist them washing and dressing." There was no other information about whether the person could wash parts of their body independently or information about how to provide choices of clothing. Another person's communication needs care plan was incomplete and had contradictory information in. We also saw a person had assessed needs for diabetes but there was no care plan in place to guide staff on how to meet their individual needs regarding this. We were assured at the time of our visits to the service, that in practice staff were knowledgeable about how to manage this person's diabetes, despite them not having contemporaneous records about the person's needs available to them at that time. Following our inspection, the provider submitted further evidence to us which included a newly written care plan about how staff should manage this person's diabetes. We found a person who used the domiciliary care service was noted to have swallowing difficulties and used thickened fluids. We were informed this information was not current. We have reported further on these records issues in the Well-led section of this report.

Care plans were not always an accurate and contemporaneous record of people's needs. This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did find some examples where people's preferences had been recorded. For instance, one medication care plan stated, "I prefer my medication with juice" and another care plan recorded what a person enjoyed doing by stating, "[Name] enjoys watching the television during the day and listening to music in the evening." Staff showed understanding of person-centred care and treating people as individuals. They could describe the care they provided for people and how this was individualised to people and their needs. People who used the service and relatives told us they or their family member's needs were met well. One relative said, "The staff are warm and friendly. They know residents as individuals."

We also saw the service had received positive feedback from visiting health professionals about the care and support people received. One health professional had said that staff had good knowledge about people who used the service and they had always found people to be well cared for. Another had said that the provider had met people's complex needs well; with a flexible approach.

People told us they were treated equally. We saw no evidence to suggest that anyone who used the service was discriminated against and no-one told us anything to contradict this.

The provider discussed the sensitive issues concerning end of life care with people and their families. We saw some people had completed support plans to show what their wishes were for end of life care.

Activities took place in the care home on a regular basis to reduce social isolation. We observed staff carrying out activities of bingo, dominoes, and arts and crafts during our inspection. We saw people were encouraged to engage. There was a lively atmosphere and people told us they enjoyed the activity.

Posters in the service advertised weekly coffee mornings, a reminiscence museum activity, Anglican communion, a sing a long, massage, chair exercises and a world cruise activity. Some of these were out of date but we saw the ones in the reception area of the home gave up to date details on forthcoming activity. Staff told us they made sure people who were cared for in bed had access to activities such as chatting and playing board games. One member of staff said a singer that came in to the home always went around the rooms to sing for people if this was what they wished.

Staff told us they had enough time to enable them to organise some activity each day. This included occasional outings such as trips to the local park or pub lunches. Some people told us they would like to get out more. A person's relative said, "[Name] has not been out since they arrived here; we would welcome [Name] going out." The registered manager told us of an initiative the provider was involved in which seeks to bring the community into the care home for those people who are unable to get out due to complexity of their health needs. The initiative had enabled people access to creative activities and had more recently commenced an intergenerational project where children and their parents had visited the service and joined in with activities.

The registered manager was aware of the Accessible Information Standard. This is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. They told us they would provide adapted information if this was needed.

The provider had a complaints policy and guidance was available to help people raise their concerns. We looked at the complaints procedure, which informed people how and to whom they should make a complaint. Most people and their relatives we spoke with felt able to raise any concerns they had with the registered manager or staff. One person who used the service and one relative said they were not comfortable raising concerns.

We looked at some individual complaints and saw these were responded to appropriately. The registered manager said learning from any complaints would be discussed with the staff team to prevent any re-occurrence of issues. Staff told us they were kept informed of important issues that affected the service delivery such as the outcome of complaints or concerns.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us they monitored the quality of the service by completing audits, gaining feedback from people who used the service and their relatives, and maintaining a presence in the service. We reviewed a range of recent audits which included medicines, cleanliness, mattresses and meal-times. We found any issues identified did not have an action plan to show how they would be addressed. For example, two mattresses were found to be stained and in need of washing. There was no record that this had been completed. Similarly, the results of a medicines audit in March 2018 stated 'To follow up on cream/ointment questions'. There were no recorded actions of what was to be done and if action had been taken.

The registered manager told us a new system of governance had been introduced in July 2018 which included monthly checks on all aspects of service provision. This included, medicines, care records, falls, dignity, infection prevention and control, maintenance and housekeeping. The records of these checks were in a numbered chart form but gave no clear information on what the findings were. We reviewed the records of the checks that had been carried out, both in the care home and the domiciliary care service. The checks carried out in the care home did not show a record of what or who's records had been audited. When shortfalls were identified, there were no action plans for how these were to be addressed.

Systems used to monitor the quality of the service were not yet fully effective in identifying concerns and protecting people from risks to their health, safety and well-being. We were unable to consistently see that remedial action was taken when issues were identified. The audits were not fully effective as they did not identify the concerns found during this inspection with regards to care records, risk management records, mental capacity assessments and medicines records.

Residents' meetings were held regularly where people could give feedback on aspects of the service such as food, laundry and staff. Records of these meetings were very brief and did not show what action was taken when issues were raised. For example, a comment that vegetables were too hard and needed cooking longer was made in April 2018. There was no record of the action taken on this.

We saw staff meetings took place and staff told us they could contribute ideas or raise any suggestions they may have. We found minutes of staff meetings were brief and did not always give a clear account of what had been discussed. For example, one record stated, 'staff don't take correction well'. There was no further information available on what was meant by this comment.

The provider did not have fully effective systems in place to assess and monitor risks relating to people's health, safety and welfare. Care plans did not always show an accurate and contemporaneous record of people's needs

This was a breach of Regulation 17(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who used the service were asked to provide feedback on the service. Quality assurance surveys were

sent out and the results from the latest survey completed in 2018 showed a high degree of satisfaction with the service. People's comments included; 'Park Lodge has a warm and welcoming atmosphere. The staff are very caring and friendly', 'Friendly staff. Nothing is too much trouble' and 'The care of my family member has been of a high standard and overall good.' '

The registered manager was supported by a deputy manager in the care home and an advanced care practitioner in the domiciliary care service. People and their relatives spoke positively about the management of both services. Comments we received included; "I know who is in charge. I feel the place is well-managed", "We have a good relationship with them [management team]. They are good, they listen to us" and "Brilliant; always there at the end of the phone should I need them which is very rarely." The management team were all described as approachable.

Staff spoke highly of the registered manager, the support they received, and told us how much they enjoyed their job. One member of staff said. "I love my job, great residents, great team; it's good to be here." Many staff had worked in the care home for several years and proudly told us of this. Staff said they would recommend the service to others and one member of staff told us their family member had been cared for at the service. The management team were respected by the staff team. Staff told us they were approachable and always available to offer support and guidance. Staff described an open culture and good communication in both the care home and domiciliary care service.

The registered manager worked in partnership with other agencies when required, for example healthcare professionals, the local authority and social workers. The registered manager told us they were currently involved in a 'posture and mobility in care homes' study. This meant they were supporting and participating in research which would contribute to the understanding of how to optimise the mobility and support for people in care homes. The registered manager also told us they had a trainee nurse associate in post who arrived following a national NHS driver to retain nursing staff within the profession. Notifications had been sent to the Care Quality Commission (CQC) by the service as required by legislation. For example, services must notify CQC about any injuries people received, any allegation of abuse, any incident reported to the police or any incident which stopped the service from running.

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 Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective system to monitor and improve the quality and safety of the service delivered to people. People received care that was person-centred, however, their care plans and some medication records were not always an accurate and contemporaneous record of their needs.