Runwood Homes Limited

Park View

Inspection report

Priory Road
Warwick
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 14 November and 15 November 2016. The visit was unannounced on 14 November 2016 and we informed the registered manager we would return on 15 November 2016.

Park View is a residential home which provides care to older people including some people who are living with dementia. Park View is registered to provide care for up to 63 people. At the time of our inspection there were 55 people living at the home.

This home was last inspected in October 2015 and was rated as 'requires improvement'. We found two breaches of the regulations relating to unsafe staffing levels and unsafe care and treatment. At this inspection we found improvements had been made, although we found some improvements where required in the management and governance within the home.

The registered manager had quality monitoring processes which included audits and checks on medicines management, care records and accidents and incidents. However, when some checks were delegated to others, improvements did not show what action, if any, had been taken to improve the delivery of service. We could not be confident statutory notifications involving serious incidents and safeguarding concerns had been sent to us.

The home is required to have a registered manager. 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 and associated Regulations about how the service is run. At the time of this inspection the home had a registered manager, however they were leaving the service at the end of November 2016. A new manager had been appointed and was receiving a handover from the registered manager. The new manager told us they would be applying to us to become registered manager.

People and relatives were complimentary about the care and support they received. People received care that enabled them to live their lives as they wanted and people were supported to remain as independent as possible. People were supported to make their own decisions where possible and care was given in line with their expressed wishes.

Care plans contained accurate and relevant information for staff to help them provide the individual care people needed, although some care plans required updating when people's needs changed. People's care and support was provided by a staff team who were knowledgeable, trained and knew people well.

People were encouraged and supported by a caring staff team. People told us they felt safe living at Park View and staff knew how to keep people safe from the risk of abuse. Staff understood what actions to take if they had any concerns for people's wellbeing or safety and if so, they had reported them to senior management. However, we found two examples of potential safeguarding incidents that the provider had

not reported to us.

Potential risks were considered positively so that people did things they enjoyed. People were encouraged to maintain relationships and kept in touch with those people who were important to them.

Staff received essential training to meet people's individual needs, and effectively used their skills, knowledge and experience to support people and develop trusting relationships.

There were enough staff to support people and the permanent staff team were being supported by agency staff whilst the provider continued to recruit to fill care vacancies. Improvements in shift management and staff tasks would help ensure people continued to receive a prompt and effective service.

The registered manager and staff understood their responsibilities in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, staff's knowledge and people's records ensured people received consistent support when they were involved in making more complex decisions, such as decisions around finances or where they wanted to live. Staff gained people's consent before they provided care and supported people to retain as much independence as possible.

People were supported to pursue various hobbies and leisure activities and further improvements were being made with the support of the dementia service manager.

People had meals and drinks that met their individual requirements and people said they enjoyed the food choices provided.

People told us they could raise concerns or complaints if they needed to because the provider, registered manager and staff were available and approachable.

We found a breach 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?

Good

The service was safe.

People felt safe living at the home. They were supported by enough staff who were available to provide their care and support when required. Staff understood their responsibilities to report any concerns about people's personal safety or if they believed people were at risk of abuse or harm. People were supported with their prescribed medicines from trained staff which ensured people received their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were cared for and supported by staff who had the relevant training and skills for their roles. The registered manager and staff understood the principles of the Mental Capacity Act (MCA) and made sure people's freedoms were not unnecessarily restricted. Staff respected people's decisions and gained people's consent before they provided personal care. Some people were assessed as requiring their food and fluids to be monitored but staff did not always accurately record what people had consumed. People had access to and were referred to other healthcare professionals when their health needs changed.

Is the service caring?

Good

The service was caring.

People were treated as individuals and were supported with kindness, respect and dignity. Staff were patient, understanding and attentive to people's needs. Staff had good knowledge of people's preferences, how they wanted their care delivered and how they wanted to spend their time, whilst promoting independence.

Is the service responsive?

Good

The service was responsive.

Staff knew the needs of the people they were caring for and supported people in line with their agreed care decisions. People felt confident speaking with the registered manager to raise any issues or concerns knowing their concerns would be listened to. People were involved in care planning decisions, and how they wanted to spend their time pursing their personal hobbies and interests.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager had systems to monitor the quality of service, however when some of the quality checks were delegated to others, improvements did not always show what actions had been taken. We could not be confident statutory notifications involving serious incidents and safeguardings had been sent to us.

Park View

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 14 November 2016, was unannounced and consisted of three inspectors and three experts by experience. An expert by experience is someone who has experience of caring for someone who uses this type of service. One inspector returned on 15 November 2016 which was announced.

We reviewed the information we held about the service. We looked at information received from relatives and other agencies involved in people's care. We contacted the local authority, who did not provide us with any information that we were not already aware of. We also looked at the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

To help us understand people's experiences of the service, we spent time during the inspection visit talking with people in the communal areas and in their own rooms. This was to see how people spent their time, how staff involved them, and how staff provided care and support to people when required.

During our inspection visit we spoke with 29 people who lived at Park View to get their experiences of what it was like living there, as well as 12 visiting relatives. We spoke with the registered manager, the new manager, a dementia service manager, regional care director and an operations director. We spoke with three care team managers (CTM) nine care staff and one kitchen assistant.

We displayed a poster in the communal area of the home inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

We looked at five people's care records and other records including quality assurance checks, complaints, statutory notifications, medicines and incident and accident records.

Good

Is the service safe?

Our findings

At our last inspection in October 2015, we found two breaches of the regulations relating to unsafe staffing levels and unsafe care and treatment. Following this report, the provider was required to send us an action plan telling us how they would be compliant with the regulations. At this inspection we found improvements had been made.

People told us they felt safe living at Park View and explained why they felt safe. People said they felt secure in the home, one said they felt safe because, "There are always people milling around" and "Yes I feel safe here, I like the security." Other people told us they felt safe because if they needed help or assistance, "They (staff) respond promptly." Some people we spoke with said they felt safe knowing they could lock their doors whenever they wanted. One person told us some people 'wandered around' and on occasions walked into people's rooms (usually by accident). They said they were not concerned because, "I have a key to my room." so could lock their door if they wished. A relative told us about their family member who had moved to the home because of challenges they faced providing care in the persons' own home. They said since their family member moved to Park View, "[Person] is well looked after here and more importantly to me, he's safer."

Staff said all external doors were locked at night which restricted opportunities for people who had no reason to enter the home or to gain access. The registered manager told us about an example where previously an ex staff member had been restricted from the home. The registered manager told us to continue to keep people safe and protected, they had changed the door code to reduce potential risk.

People were safe because they were protected from the risks of abuse or poor practice. Staff understood the different types of abuse, the signs to look out for and the actions to take if they had concerns about people's safety. Staff understood their responsibilities to share any concerns that people might be at risk of abuse. A typical comment was, "If I had a concern I would speak to the CTM at first and then speak to the actual manager." There were copies of the provider's whistleblowing and safeguarding policies displayed in the registered and care team manager's office, to remind staff of their duty and rights related to sharing concerns.

Permanent and agency staff told us they had training in safeguarding and knew what they should do if they had any concerns about people's safety. Staff told us, "Abuse is mistreating people, even just how they are spoken to" and "I would whistle blow (raise concerns internally or to other health professionals), but I have never had any concerns about people's safety." A staff member told us they were confident to share any concerns with their line manager, not just about staff's behaviour or approach, but their observations of how people responded to different staff's approach, to ensure a good match between people's needs and staff's behaviours. The registered manager knew what action to take and when concerns were raised to them, they notified the safeguarding team. They said they would and had contacted CQC. However, in the registered manager's absence, we found two safeguarding incidents had not been raised with us and only one incident had been referred to the local authority safeguarding team. We spoke with the regional care director who agreed to submit these statutory notifications and notify the relevant bodies without delay.

Risks to people's individual health and wellbeing were assessed and action taken to minimise those risks. Where risks were identified, people's care plans described the actions care staff should take to minimise them. Risks to people's mobility, nutrition and communication were assessed and staff were given guidance on managing the risks to ensure the best outcome for the person. Staff understood people's individual risks and supported them appropriately. For example, for one person who was not able to mobilise independently, their care plan explained the number of staff and the type and size of equipment staff should use to support them to move. We saw staff used the equipment in accordance with the person's care plan. Another person had recently moved into the home for respite care, after being discharged from hospital. This person's relative said they were encouraged staff were mindful of people's safety. They said they were impressed that the staff found a suitable walking frame for their family member to use, until other family members arrived with their own frame from home. One person told us they felt risks to their safety were being managed well as they were prone to falling. They said, "I have never fallen here and I did at the other place."

Staff knew about people's individual needs for support and explained the actions they took to minimise risks to people's health and wellbeing. For another person, whose ability to mobilise independently fluctuated, staff told us, "It depends on how [Name] feels at the time." On each occasion that the person wanted to move from one place to another, we saw staff invited and encouraged them to maintain their independence, but recognised when the person needed more support to move safely.

We received mixed opinions from people and relatives about staffing levels within the home and whether there were enough staff on shift, who knew what their needs were. Comments made were, "They respond promptly if I call for help", "Can't complain- they come as quick as they can" and "They need more staff when you ring the bell you have to wait sometimes 10 to 15 minutes." During our inspection visit, we saw there were enough staff to respond to people's individual needs for practical and emotional support and call bells were answered promptly. People told us staff had time to sit and talk with them about subjects that interested them, such as their families and events they planned to attend.

People's care plans included people's individual dependency assessments which determined how many staff were needed to support them safely. The registered manager used dependency assessments to decide how many staff were needed on each shift, across the week. The registered manager told us there were not enough permanent staff to fill all the care hours required. The registered manager used 350 hours agency staff per week, to make sure staffing hours met people's needs. The high use of agency staff was noticed by people living at the home. People and relatives believed staffing levels were low because of the lack of permanent staff, rather than not enough staff to support them. Some people had experienced some delays, but the majority of people were satisfied. A typical comment was, "The staff do a wonderful job but we need more so there are less agency because they are not so conscientious, there is agency every day" and "The staff do a great job but they are understaffed - you can tell because of the temporary staff they have."

Care staff and CTMs told us there were enough staff on the rota to support people, but the combination of agency and permanent staff on each shift was not always considered when the rota was completed. Agency staff did not know people so well. We saw they required direction from permanent staff which meant valuable time was taken, which people told us, on occasions delayed their response to calls for assistance. A member of staff told us, "I am constantly explaining to agency staff and watching them to make sure they get it right." They told us they felt responsible for overseeing agency staff and this was twice as demanding when the ratio of agency to permanent staff was two to one. They felt they could not give people the attention they deserved while they were so conscious of the need to direct agency staff. This particular ratio of agency to permanent staff made them feel there were not enough staff to support people in the way they needed.

The provider was recruiting care staff at the time of our visit. The new manager and regional care director recognised they needed their own bank of permanent staff to reduce their reliance on agency staff, unplanned absences and improve staff's time management. Staff told us they regularly picked up additional shifts and worked longer shifts to ensure agreed staffing levels continued to be met.

Medicines were managed, stored and administered safely, in accordance with best practice guidance. Staff told us only trained care team leaders administered medicines. A care team leader showed us how people's medicines were managed and administered safely. Each medicine tray was accompanied by a pre-printed medicines administration record (MAR) with the person's photo for safe administration. Records showed staff recorded when medicines were administered or recorded the reason they were not administered. The care team leader told us that some people needed regular injections of a medicine and these were administered by a district nurse. They told us the district nurses kept their own records of when the medicine was administered, but staff made a note on the person's file when the district nurse arrived, to ensure any changes in the person's care were known to all staff.

The CTM showed us how they managed medicines that were supplied in boxes, for example, medicines that people brought with them when they stayed at the home for a short time, and various medicines prescribed for 'as and when required' or PRN medicines. They counted all the tablets when they were received into the medicines store and made a record of how many were administered and how many were left on each occasion they were administered. They told us this was useful to remind relatives to re-order medicines for people on short stay visits and for the auditor when they checked medicines were managed and administered safely.

For one person who was not able to express themselves verbally, there was a written protocol, or guidance for staff, for administering as and when required [PRN) calming medicine. The protocol explained the signs staff should look for that the person might be agitated so they would know when to administer this medicine appropriately. However, there was no protocol for administering PRN pain relief for this person. Records showed different staff interpreted the person's signs differently and they were not consistent in their reasons for giving the person pain relief medicines. The manager agreed to improve the PRN system so staff consistently administered PRN medicines safely and in line with safe dosage limits.

Effective systems kept people safe in an emergency. These included regular fire alarm testing and fire equipment checks. Each person had a personal evacuation plan that provided the emergency services with important information about their mobility and any equipment needed to evacuate them safely. People's levels of mobility was identified by a coloured dot in their file, which corresponded with the same coloured dot on their own personal room door, designed to ensure a smooth and planned evacuation.

Requires Improvement

Is the service effective?

Our findings

People told us staff knew how to support them and knew how they wanted their care delivered, in line with their individual choices. Staff demonstrated an understanding of people's needs and how best to care for and support them. People received care from staff who had the skills and knowledge to meet their needs effectively. One person was complimentary of staff, saying, "I think we were spoilt by some carers (staff) a little…they are fantastic." Another person said, "The staff here are well trained."

The registered manager used a system that identified when staff training required updating. The registered manager told us staff were regularly booked on training sessions to ensure their knowledge remained updated. A staff member told us training was part of their induction programme. They said they had training in using a hoist and slings and other techniques in supporting people to mobilise safely, and said their competence was checked by the trainer. They told us they were working through the Care Certificate, as they had only been in post for a limited time. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff working in a care environment.

Agency staff told us they had an induction to the service and worked with permanent staff to learn about people's needs before they worked independently with people. They told us they had to attend training with their agency, and their competence in supporting people was checked and signed off before they were sent on assignments. Some agency staff told us they worked with the same group of people for several weeks and had developed their knowledge about people's individual needs and abilities. They felt confident at delivering one-to one care because they knew people better and people were used to them. They demonstrated their knowledge by explaining how they supported different people with their different needs. They knew which people needed one or two staff to support them and the reasons why.

The dementia services manager supported staff with dementia training, as well as providing ongoing support and developing staff knowledge to support people living dementia. The dementia services manager said all staff were receiving a two day dementia leadership course, to understand dementia care and to provide, 'Better links between other homes and to use their knowledge to make a difference." They said, "We are here to provide a life to people, get people talking and involved in what's important to them, past histories, families." Life histories had been completed with help from people and families which were used to generate new conversations and for staff to get to know people better.

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. We checked whether the service was working within the principles of the MCA. People's care records included individual mental capacity assessments for people's understanding and memory, confirmed which decisions people could make for themselves and which decisions should be made in their best interests. A staff member told us the registered manager had a copy of the documents issued by the courts so they could be confident that people's relatives and representatives had the legal right to make

decisions on their behalf. One relative supported this, saying, "I am involved because my [relative] does not always know what to choose."

People's care plans explained which decisions staff should make in people's best interests, if they were unable to make decisions. For example, for one person who lacked capacity to make decisions, staff made everyday decisions about how to support them with personal care and to maintain their nutrition and health, but the decision for them to live at the home had been made by a team of healthcare professionals and relatives.

Staff understood their responsibilities under the Act. A staff member told us they had not yet completed the element of the Care Certificate that covered the legal obligations under the Act, but they understood that capacity could fluctuate and depended on the complexity of the decision to be made. They explained that people's capacity to weigh and remember information was often related to the impact and progression of dementia. We saw staff understood the principles of the Act and assumed people had capacity to make everyday decisions. Staff checked with people whether they wanted assistance before supporting them. For those people who were unable to communicate verbally, staff told us they maintained eye contact and watched the person's facial expression and body language, to understand whether they consented to support.

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). The registered manager had identified 16 people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority which had been granted. The registered manager and a representative from the provider assured us they understood their legal obligations to comply in totality with all conditions attached to a DoLS authorisation.

People had a choice of meals and chose where they would eat them. At lunchtime, most people ate in the dining rooms on each floor. People were supported to choose what to eat, by staff showing them two plated sample meals. Each meal was then served while it was hot. Some people chose to eat in their own room and we saw staff took their meal to them while it was still hot. People were supported to eat independently by the use of appropriate equipment and staff support. For example, one person who was visually impaired had a plate guard and brightly coloured bowl, which enabled them to see their food better and eat independently. Staff offered to cut-up food if people found it hard to cut, but otherwise enabled people to eat at their own pace and to enjoy their meal. Staff encouraged and offered assistance to people if they did not eat independently. After lunch people were offered a cup of tea or coffee and encouraged to linger at the table in conversation with staff and others, while they digested their meal.

At our last inspection we found staff did not accurately record for those people identified at risk of dehydration and malnutrition, what they had consumed. We saw some examples where staff had recorded inaccurate quantities and meals that people had not eaten. This meant inaccurate recording could lead to some people spending long periods of time with insufficient food and drink, and could delay any further support or intervention being provided. Before we undertook this inspection, we received some concerning information that suggested improvements had not been made. At this inspection visit we followed this up. We found examples of some food and fluid charts which were not being recorded in line with the provider's expectations, were not being checked and in some cases, did not accurately record what people had eaten or drunk. We spoke with a CTM who was responsible for checking these records but they could not provide us with a satisfactory response as to why they were not completed correctly. Additional checks by the deputy manager had not identified the concerns we found and we shared our concerns with the regional

care director.

People were supported to maintain a balanced diet that met their needs and preferences.
People's care plans included their food preferences, allergies, and whether they could eat only 'soft' foods, for example. Staff told us they knew people's individual likes and dislikes, as well as their allergies and dietary needs, because they knew people well and read their care plans. People's dietary needs and allergies were shared with the cook. For example, the cook had made a standard and a diabetic version of 'todays' pudding and staff knew who required the diabetic option.

People told us they had access to, and used the services of other healthcare professionals. One person said, "The office sometimes arranges hospital appointments…I had an optician's appointment - got new glasses." Records confirmed people received care and treatment from their GP, district nurses and chiropodists. Relatives told us whenever other healthcare professionals were involved, they were kept informed about any decisions, treatments or advice given.

Good

Is the service caring?

Our findings

People were supported by kind and caring staff and were complimentary about the staff who provided their care. Comments people made were, "Yes staff take time to treat me as an individual… they listen", "They (staff) are interested, they sit and chat all the time" and "The staff are very good…they work under difficult circumstances but they do not show this when they are caring for the residents…they are calm and professional." People said staff knew them well and understood the things they enjoyed. One person said, "Staff know me well- they know I like to read" and another person said, "Staff are interested in me as a person, we chat about my experiences in the army and my travels."

One relative told us about their experiences of how the staff cared for their relative. They said their relative needed some assistance and said care staff were, "Lovely on this floor (second floor). [Person] has everything he needs here. All the staff like him, they help him with his food." This relative told us about what it meant to them, knowing their family member was being well cared for. They said, "I have peace of mind and they always keep me informed." Another relative said they were involved in their family members care routines which they were pleased with. They told us they applied prescribed cream to their relative's legs and that they wanted to continue to do this because, "I understand his needs and like to do these jobs for [person]." They explained, "Staff are happy for me to take on this role as long as I keep them informed of any changes I find." This relative told us this arrangement worked well and ensured their family members wellbeing and important relationship was maintained. They said, "He's well looked after here."

We saw people were treated with kindness and thoughtfulness by staff who knew them well and understood them. Staff understood their own behaviour and attitude made a difference to people's experience of the service. We saw people's facial expressions relaxed when staff touched their shoulders or arms while talking with them.

Staff greeted people as they came into the lounge and ensured people were able to sit comfortably in their chosen place. We heard staff say, "[Name], shall I pop this cushion under your head, to make sure your neck doesn't hurt?" and "[Name], would you like to sit with [name]? Come on then." We saw staff re-arranged the chairs to make sure the two friends could sit together. They both looked pleased and relaxed with this arrangement. The staff member asked people whether they wanted to watch a film or a television programme. They gave the television controller to one person who showed an interest in making a choice, which helped promote their independence. The activities co-ordinator came into the lounge and reminded everyone about the raffle and musical event that was planned for the afternoon, which gave people something to look forward to. Before the raffle commenced, a person living at the home began singing opera to people and relatives who had gathered in the room. Some people joined in and people applauded the person at the end of the song. People, relatives and staff asked us, 'Did you hear this person's singing'. We did and saw the pleasure it brought to those who heard this person.

Staff told us it was important to know people well and understand their history, motivation and important relationships in order to deliver care and support in a 'person centred' way. People's care plans included a family tree, a brief social history and a description of 'My day' from the person's perspective, which included

their interests and preferred routines. Life history books had been completed and were being checked by the dementia service manager before being included in people's rooms and care plan records. The dementia service manager said this was useful information that would help all staff engage and stimulate conversation.

The environment promoted people's wellbeing. Communal rooms were large, light and arranged to enable small groups of people to engage in separate activities at the same time. There were 'tea rooms' where relatives could sit and take tea with their relations in a smaller, more personal space. The provider had used large picture signs to direct people to the different rooms and to help them find their way around the home independently.

People were supported to maintain their dignity and were treated with respect. Everyone we saw wore clean clothes, and their nails were clean and manicured. We saw a staff member supporting people by making sure all their buttons were done up and their hair was brushed, which helped them maintain their dignity. When one person came into the lounge with unbrushed hair, we saw a staff member brush their hair back with their hands and say, "You take a seat there and I'll go and get your brush", which they got. We saw the person smiling back at staff as they brushed their hair. Staff told us the central value of treating people with respect was to, "Put yourself into their shoes" and "Treat people as you would want to be treated yourself."

Staff respected people's privacy. For one person who stayed in their room, we heard staff call out to the person by name, announcing who they were before entering, to make sure the person was happy for them to enter. People said whenever personal care was provided, they felt comfortable with staff and their privacy was maintained and respected. One person gave us an example of how staff did this, saying, "When I have a bath they (staff) stay with you. They always shut the door which puts you at ease."

Good

Is the service responsive?

Our findings

People told us their needs and wishes were responded to although at times, some people experienced delays between requesting help and receiving it. A relative explained to us that staff worked hard and attended to people's needs but, "When I need the staff I often have to go and look for them. They often have to double-up." Another relative supported this, saying "They have an enormous difficulty with a shortage of staff." From our observations during our inspection visit, we found staff were busy, but were able to meet and respond to people's needs, as well as observing people to ensure they remained safe and cared for.

Staff understood and responded to people's anxieties and fears, speaking reassuringly with them. For example, when one person voiced their anxiety about their relative, staff took their arm and reminded them when their relative would next visit. They offered to walk with the person and to have a cup of tea together. The person appeared less agitated after staff's re-assurance and went with them to the lounge.

People and relatives were involved in planning their care and support. One relative said, "Yes I think there are on- going reviews, I have one scheduled…just have to double check when." For people who were not able explain how they wanted to be supported, because of their complex needs, records showed their families were involved in planning their care. The registered manager checked people's representatives were authorised to speak on their behalf. Relatives said they were kept informed if there had been changes or events they needed to be made aware of. For example, one relative said their family member had fallen. They told us, "They (staff) rang me in the early morning to say [person] had a fall in the night and they spent some time with her settling her down until she went back to sleep. They handled it just as I would have liked." This relative felt reassured staff took the necessary action and said, "[Persons name] is safe here."

Staff knew the people they supported although some staff said they did not always have time to read all of the persons' care records. Speaking with staff showed us some inconsistencies in staff knowledge and records. For example, one person had recently moved to Park View. They had been assessed as 'at risk of falls' and following their move to Park View, had fallen. Following their fall, their care plan had not been updated and some risk assessments contradicted each other which meant staff did not always have accurate information to respond to people's changing needs. However, the staff team were confident they knew how to support this person to reduce any potential risks off falling, such as their personal environment and using alarm mats by the persons' bed. We spoke with the registered manager about this and they agreed to update this person's care plan, as well as reviewing all care plans to ensure people's care plans provided a complete and accurate picture. The new manager and regional care director had recognised this was an area that needed improvement so they were confident people's needs were met.

CTMs completed monthly care plan reviews. Records showed people's needs and dependencies were regularly re-assessed to identify whether their care needs had changed. For example, one person had been assessed as at risk of falling from their bed, while they were able to mobilise independently. The use of bed rails had been considered, but discounted because the person was at greater risk of trying to climb over them. Since the person's mobility and awareness had decreased, the care plan identified that a rail and protective bumper on their bed would protect them from the risks of grazes, while a lowered bed and

padded crash mat would continue to protect them from injury if they fell.

People were supported to maintain their interests and preferred pastimes and had opportunities for purposeful activity and socialising. Staff told us they usually knew about people's interests because people or their representatives had explained how they enjoyed spending their time when they first moved to the home. People's history, interests and preferred social activities were explained in their care plans so staff knew the topics of conversation people might enjoy. We saw staff were skilled at engaging people and making them feel valued.

During the morning of our inspection visit, one member of staff played a board game with one person and another member of staff played guessing games with a small group of people. When the member of staff started singing a well-known song, several people joined in, including people who had not seemed to be paying attention to the guessing game. This demonstrated the technique was successful at promoting personal memories. A member of staff told us the activities co-ordinator was always thinking of new ways to engage people in purposeful activities they enjoyed. They told us the activities co-ordinator spent time with people one-to-one, as well as organising group activities. The member of staff said, "People think the world of the activities co-ordinator."

The activities co-ordinator had planned a raffle and musical event during the afternoon of our inspection visit. They walked around the home in the morning to remind people and to encourage them and relatives to attend. A dementia services manager told us how people with complex needs were supported and encouraged to maintain their skills and interests. They had developed some techniques for staff to adopt to make the most of opportunities to engage with people. There was a glass jar in reception for all staff to 'take a cookie' from. The cookies were pieces of paper with suggestions staff should use that day to engage people in conversation and activity, whenever the opportunity arose. There was a list of ideas in the lounge to remind staff that 'purposeful activity' included anything that supported people to enjoy the moment. The dementia services manager said things had improved a lot since the last inspection and they continued to deliver and try new ways of engaging staff and people to 'seize the moment' and 'become involved'.

People and their relatives knew how to complain about the service and comments demonstrated they felt confident to raise concerns and action would be taken. A typical comment was, "I have no complaints, but should I have any, I will just ask the manager" and "I have no concerns - never have, I get what I need when I need it." Relatives said if they were unhappy with the service or wanted to raise their concerns, they felt confident to do so and knew who to approach. One relative said they had 'verbally' raised their concerns about the effectiveness of how laundry was managed. They said, "I have now labelled all of her drawers and wardrobe space so that clothes go back where they should and I can easily check whether she has enough for the next day. They say they don't mind that I have taken these measures."

Information was available that informed people how to complain and the timescales for responding to complaints. We looked at how written complaints were managed by the service. Actions were documented, investigated and responses sent to people. The registered manager said all complaints received had been resolved to people' satisfaction, and processes were improved where required, to reduce potential for similar complaints.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the home in October 2015 we identified two breaches of the regulations. One breach related to unsafe staffing levels which had an impact on the quality of care people received, resulting in a second breach for unsafe care and treatment. Following this report, the provider was required to send us an action plan telling us how they would be compliant with the regulations.

At this inspection, we looked to see if the required action had been implemented to meet the regulations. We found some action to improve had been taken such as increasing the staffing numbers to support people's needs. Speaking with people and from our observations, we saw staff were able to support and meet people's physical and emotional needs and ensure they received safe care and support. However, we found insufficient action had been taken to improve the systems and processes to effectively monitor and assess the quality of the service and provide effective leadership and oversight of delegated tasks.

For example, at our last inspection we found some staff did not accurately record what people had eaten and drunk. We found staff recorded people had eaten a full meal and dessert, when in fact, they had not eaten anything. To address this, the providers action plan said, 'care staff complete nutritional records as evidence and records are completed immediately following their meal'. Their action plan also said, 'CTMs to evaluate all food and fluid charts throughout the shift and sign as evidence of documentation'. We found examples where fluid charts were not completed and not checked by CTMs. We checked four people's food and fluid charts. In the last three days, they all failed to record any drinks given from 5.00pm to 7.00am. Staff told us, "People have drinks, there is a drinks trolley at 7pm" but no one gave us a reasonable explanation why they had not recorded this. We asked a CTM about the checking process. They said, "We do check daily." We showed them gaps in one person's records. They said, "I don't know, they should be checked."

We looked at people's food charts for those people identified at risk to check staff accurately completed them so risks to people, where being managed. We found some food records did not accurately record what people had consumed, and they were not completed in line with the provider's expectations which had potential to put people at increased risk. Staff told us they filled them in at lunchtime (12:30pm) when people were eating but this was not being done. We asked one care staff member for the food records at 1:40pm. They said, "Give us a chance, you can see how busy we are." We were given the completed records shortly after but they were not accurate.

For example, we observed two people at lunchtime and reviewed their food and fluid charts. For one person, records showed they had sausage meat plait, vegetables and gravy. This was recorded as (F = all eaten), chocolate mousse (F)'. We observed this person and they had vegetable lasagne, not sausage plait and none of the vegetables served with it. Therefore this person's meal type and amount was recorded inaccurately. Another person's records stated, 200ml juice, sausage meat plait veg and gravy (F), chocolate mousse (F).' We saw this person had a smaller glass which the home's records stated held up to 180ml and this was only filled ¾ full. Therefore the drink was inaccurately recorded as 200ml. In addition, the person had eaten less than half their meal, so the quantity of food was also recorded inaccurately.

We spoke with the deputy manager who was responsible for checking these forms. The deputy manager explained they completed a 'Daily floor Audit' during the day which included monitoring people on food and fluid charts. We saw they had recorded both people we observed as 'exceeded totals' for food and drink. These totals came from the charts we observed had been filled in incorrectly at lunch time. There was no effective monitoring or checks to ensure records were completed and accurately reflected what people had. This is important, especially for people identified at risk and who may receive support from dieticians or other healthcare professionals.

We found other concerns regarding the quality and accuracy of recording. We checked accident and incident records. We saw an internal investigation by the deputy manager had taken place in September 2016. Records suggested a person living at the home had been left in their wheelchair from 7:00pm until 08:00am the following morning, without getting undressed, or being put into bed. The deputy manager told us they spoke with the staff member on duty and analysed the records night staff had completed. The deputy manager told us there was a discrepancy between the records and what the staff member told them. We saw daily checks and daily observation records had recorded this person was checked hourly, yet the deputy manager and the person left in their wheelchair, believed this was not the case. The deputy manager told us they had reported this to a senior manager (no longer at the service). We asked the regional care director whether this should have been reported to safeguarding and us by way of a statutory notification. They responded, "Yes, that's safeguarding." We also found another safeguarding incident in August 2016 that should have been referred to us as a statutory notification. The regional care director agreed to submit these retrospectively to us without delay.

The provider's audit system required further improvement because they had not identified some of the concerns we had identified. The issues we raised regarding incidents and accidents should have been referred to us. Medicine audits were completed but these had not identified the concerns we found regarding staff administering PRN medicines. Records showed different staff interpreted the person's signs differently and they were not consistent in their reasons for giving the person pain relief medicines. The system of checks regarding food and fluid chart completion and monitoring was not effective.

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

People were complimentary about the registered manager, staff team and how the home operated. People felt they could approach the management and staff. Comments people made were, "I know the manager - here she comes! She is fantastic, very sad she is leaving", "A happy place to be, we get on well and can celebrate important events like Christmas" and "The best thing about being here is: It's warm, cheerful and lively, I don't feel lonely. Relatives were equally positive, saying, "We contribute all the time- we attend reviews", "Rooms are clean and lovely" and "Good Management - they try their best, they keep you informed."

People and relatives felt involved in the home and were asked for feedback about the service at regular meetings and through the provider's annual surveys. If actions were required, people said improvements were made, for example, improving the laundry system.

We looked at the management checks and audits that monitored whether the service was safe. We looked at examples of completed audits such as health and safety, water quality checks and fire safety. Regular monitoring made sure people received support in an environment that kept people safe and protected.

The registered manager was leaving at the end of November 2016. A new manager was in post and was

receiving a handover and support from the registered manager and senior management. The new manager felt supported by the provider following their appointment and told us they were committed to delivering improvements to ensure people received a quality service. During the second day of our visit, the deputy manager explained some tasks completed by night staff, such as 'hourly checks'. The regional care director and the new manager were not aware hourly night checks on people took place. The regional care director said these checks could affect people's dignity and agreed to review this practice. This example identified tasks staff completed without full knowledge of management. We talked about how this could affect staff being responsive when they were involved in other tasks, especially those the provider was not aware of. The new manager said they would look at this and speak with staff to determine what staff did and how their time could, if needed, be managed more efficiently.

People's personal and sensitive information was managed appropriately and kept confidential. Records were kept securely in the staff office on each floor so that only those staff who needed to, could access those records. Staff updated people's records every day, to make sure that all staff knew when people's needs changed although some required further improvement to ensure they remained accurate so people continued to receive the right levels of support.

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 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1)(2)(a)(b)(e).