C T C H Limited

Parton House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This was an unannounced inspection which took place over two days on the 20 and 21 April 2015. Parton House provides care for up to 36 people. Accommodation can be provided for people who wish to live together. People have access to three lounge areas, a dining room, en-suite bedrooms, and assisted bathrooms. The grounds around the home are well presented and accessible to all people. At the time of our inspection 34 people were living there. There were 15 people who had been diagnosed as living with dementia.

The home has 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 2008 and associated Regulations about how the service is run.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not protected people against the risks of unsafe moving and handling procedures. New staff had been appointed without first checking why they had left former employment with children or adults. You can see what action we told the provider to take at the back of

Summary of findings

the full version of the report. There were inconsistencies in the way in which medicines were managed and administered. People's engagement with staff and activities fluctuated according to the demands on staff.

Before people moved into the home their needs were assessed with input from their relatives to make sure Parton House could provide the care and support they needed. From these assessments individualised care plans were developed which considered any risks which might impact on people's safety. People were supported to maintain their independence whilst hazards were minimised. Where necessary referrals were made to health care professionals for advice and support. If specialist equipment or adaptations were needed to keep people safe from harm these were provided.

People's needs were understood by staff who worked hard to provide care and support at times when people wanted it. People were supported to stay healthy and well through a nutritional and balanced diet and access to social and health care professionals. When people's needs changed staff responded by raising their concerns and the care was adjusted to help people stay well and safe. Any accidents or incidents were fully recorded and action was taken to prevent them happening again.

People's views and feedback were used to improve the service they received. Their relatives and staff also raised concerns or issues which were listened to and resulted in positive changes to the service. People were comfortable raising concerns. A person told us, "We get on ever so well - all of us. We're ever so friendly here ."

Quality assurance systems included feedback from people, their relatives, staff and professionals. Quality audits monitored the standard of service provided and identified actions for improvement. A member of staff told us, " We give the best care we can."

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People were not always kept safe from potential harm. Poor moving and handling procedures put them at risk of injury.

Gaps in the recruitment and selection process for new staff could potentially put people at risk of harm, by the appointment of staff who had not been fully checked. People's assessed needs determined staffing levels, although staff reported being under pressure at key times.

Medicines which were not always stored safely. This could place people at risk of harm.

Strategies were in place to protect people from the risks of potential abuse.

Is the service effective?

Good

The service was effective. People were supported by staff who had the opportunity to acquire the knowledge and skills necessary to meet their needs.

People's consent to provide their care and support was sought in line with the Mental Capacity Act 2005. Where people were deprived of their liberty the relevant authorisations were obtained to keep them safe from harm.

People were supported to stay well and healthy. Their nutritional needs were assessed and a healthy diet was provided. They had access to health and social care professionals.

Is the service caring?

Good

The service was caring. People were treated with kindness and respect. Staff understood their personal backgrounds and their preferences for care and support.

People were given information about the service they would receive and were involved in planning their care.

People and their visitors had the privacy they needed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Although an activities schedule was in place, people did not always have the opportunity to take part in activities of their choice. Daily routines did not always allow for staff to engage socially with people.

People's preferences for their care and support were identified in their care plans. Staff encouraged people to be independent and took the appropriate action in response to their changing needs.

Summary of findings

People, their relatives and staff were comfortable raising concerns, which were listened to and acted upon to improve people's experience of care.

Is the service well-led?

Good

The service was well-led. The views of people were used to improve the care and support they received. Quality assurance systems monitored the standards of the service.

The registered manager was open and accessible, challenging poor practice and supporting staff to improve when needed.

Quality monitoring by the provider was used to drive improvements and ensure they were sustained.

Parton House

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 20 and 21 April 2015 and was unannounced. One inspector and an expert by experience carried out this inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert's area of expertise was caring for older people.

Prior to the inspection we looked at information we held about the service including feedback from the local authority commissioners and notifications. Services tell us about important events relating to the service they provide using a notification. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and what improvements they plan to make.

As part of this inspection we spoke with 14 people who use the service, five visitors, the registered manager, a representative of the provider, five care staff and the cook. We also reviewed records relating to the management of the home which included, four care plans, daily care records, records for five staff, training records and quality assurance systems.

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. After our visit we received feedback from a health care professional.

Requires Improvement

Is the service safe?

Our findings

People were not always being protected from the risks of injury or harm due to poor moving and handling techniques by staff. For example, staff supported one person to move from an easy chair to their wheelchair by supporting them under their arms. This procedure could cause injury to the person. The person's care records clearly stated they were to be encouraged to transfer themselves with the prompting from staff. Another member of staff later followed this guidance safely.

Concerns had previously been raised with us and the provider about poor moving and handling practice. The registered manager said they had addressed this and staff had been prompted to use correct and safe procedures. In light of our observations the registered manager said all staff would be alerted to unsafe moving and handling procedures and would attend refresher training. Poor moving and handling practice would be dealt with through supervision or the disciplinary procedure. We found people were not receiving care and treatment in a safe way when being supported with standing and walking tasks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could potentially be put at risk due to gaps in the recruitment process. Most checks and information were carried out prior to staff starting work in the home. They provided an application form with a full employment history. Proof of identity and a satisfactory Disclosure and Barring Service (DBS) check were in place. A DBS check lists spent and unspent convictions, cautions, reprimands, final warnings plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. References had been requested from the last employer and to check the character of new staff. However, where staff had worked previously in health or social care positions no checks, with all the employers listed, had been made to assess the reason why they left that employment. This could put people at risk of harm by employing staff who were not of good character or competent to carry out their role.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed and kept under review to determine the appropriate levels of staff required to meet their needs. Staff had previously raised concerns about meeting people's needs over the lunch time period. For example, staff said they could not help people to eat their meals and respond to calls for help with personal care. The provider's care hours calculator was used to assess the levels of staff needed. In response to staff concerns, the registered manager discussed with them how staffing hours and duties could be adjusted to improve people's experience during this time.

Over tea time staff experienced similar problems and said they needed additional support at this time too. By this time of the day additional staff and the registered manager had left and so could not be called on to help out. Call bells for three people in their rooms were ringing for over five minutes whilst staff attended to people helping them with meals. Of these one call was for help with personal care which was provided. A person told us, "They're (staff) always rushing around doing things for people". Staff also said they were extremely busy at weekends when they needed to respond to an influx of visitors. The registered manager said they would discuss with staff how best to organise their duties during peak times.

People were not always being safeguarded from financial abuse. A number of thefts had been reported to police, the local authority safeguarding team and to the Care Quality Commission. People and staff had been advised to make sure their personal belongings and money were kept securely. People had secure facilities in their rooms although one relative said they did not have a key for this. The registered manager said she would check with people to make sure they had secure facilities for their belongings. Some people were supported to manage their money. Checks were in place to make sure balances were correct and receipts were kept for all purchases.

People's medicines were not always kept securely. During a medicines round staff left medicines on two occasions on top of the trolley whilst they took medicines to people in their rooms. Staff acknowledged the medicines should have been locked away securely. People received their medicines when they wanted them and where they wanted them. People were offered eye drops during lunch time and asked if they would prefer them later. Staff confirmed creams were administered in the privacy of their rooms.

Requires Improvement

Is the service safe?

Medicine administration records (MAR) were completed correctly after people had taken their medicines. The stock levels of medicines were recorded on the MAR and medicines which were not needed were returned to the pharmacy. Any spoiled or refused medicines were safely put into labelled returns envelopes. A record was kept of returns to the pharmacy. Where people needed medicines 'as required' a protocol described the maximum dose and when these should be used. The GP had authorised the use of over the counter medicines. Some people administered their own medicines and staff checked to make sure they were taking these appropriately. Secure facilities in their rooms had been provided for storage. Medicines which needed to be stored with additional security were audited throughout the day to make sure the correct stock levels were in place. Robust records for these medicines were being kept.

People were protected by appropriate safeguards where poor practice was reported or observed. Procedures were in place to take action against staff who breached their code of conduct or their contract of employment. The provider had taken the necessary action when needed to address poor practice through the use of the disciplinary procedure. Staff were confident in the use of the whistleblowing procedure and had raised concerns with the registered manager.

People were kept safe from the risks of harm by staff who understood how to recognise potential abuse and how to report it. Staff completed safeguarding training and were confident any concerns they raised would be looked into and dealt with appropriately. They recorded any bruising or injuries to people and where these were unexplained raised them immediately with senior staff. People had access to an easy to read safeguarding procedure telling them how to recognise abuse and what to do about it.

Local and national safeguarding procedures as well as the provider's own safeguarding procedure were available in the office. Safeguarding information was also displayed around the home.

People were safeguarded against any hazards they faced by risk assessments which identified how hazards were minimised and reduced. Where people were at risk of slipping or trips, moving and handling risk assessments gave staff step by step instructions about how to support them and what equipment to use. For people with poor skin condition risk assessments described the strategies in place to prevent their skin breaking down such as applying creams, repositioning them and providing pressure relieving equipment.

When people had accidents and incidents these were recorded and people were monitored closely for 24 hours. Records were maintained evidencing any action taken and where emergency services or other health care professionals had been contacted. Auditing of these records by the registered manager highlighted where any trends were developing and further action needed to be taken such as referral to the falls clinic.

Each person had a personal evacuation plan in place which described how to help them leave the home in an emergency. A very clear summary using pictures provided staff with the information they would need at such a time. Evacuation procedures were displayed around the home. An out of normal working hours service was provided by managers should staff need advice or support. An emergency folder provided staff with information about what to do if they had a problem with utilities, missing persons or other incidents. There were health and safety checks in place to make sure the environment was managed safely. Equipment, such as hoists, assisted baths and wheelchairs were serviced at the appropriate intervals.

Good

Is the service effective?

Our findings

People told us staff were "good" and "lovely". Staff understood people's needs and the way they wished to be supported. For example, even though staff knew people's preferences for food or activities they still asked people and did not assume they wanted their usual choice.

People were supported by staff who had the opportunity to acquire the skills and knowledge to support them. Staff said they had completed an induction programme and shadowed existing staff. The induction programme was equivalent to the skills for care common induction standards. These were nationally agreed minimum training standards for new staff. The provider was aware of the new care certificate which will help them to monitor the competences of staff against expected standards of care. The registered manager was due to attend a conference to gain further information about how to implement this. The provider information return (PIR) stated they would, "Continue the programme of blended approach training (online training provider who allows us to offer more frequent updates as well as common induction standards assessments, face to face training and distance learning)".

Each member of staff had an individual training record and copies of certificates of courses they had completed. Most staff had completed training or refresher training considered as mandatory by the provider such as food hygiene, safeguarding, moving and handling and fire. Additional training had been provided in dementia awareness, hydration and equality and diversity. The registered manager confirmed challenging behaviour training was being arranged at the request of staff. The provider closely monitored the training summary and prompted staff to make sure their training was completed. The registered manager had started to carry out observations of staff to confirm they could put their knowledge into practice. She said she intended to increase observations of staff to ensure their competency. This would identify areas where staff were not competent such as moving and handling. Staff completed knowledge questionnaires as part of their learning.

Staff were being supported by management through individual support sessions where they discussed their role and responsibilities and their learning needs. A schedule had been put in place indicating staff would have meetings every two months. An annual appraisal had also been scheduled to reflect on the performance of staff. This schedule was closely audited by the provider to make sure it was being followed. Staff had attended between one and three individual meetings during 2015. Group support sessions were held to reflect on best practice such as the administration of medicines. Two staff meetings had also been held to exchange ideas and good practice.

People living with dementia were cared for by staff who had a basic understanding of their condition. The registered manager was a dementia lead and also a dementia link worker. She met with other dementia leads within the organisation to promote best practice and also with an external organisation. Some minor changes had been made to the environment and the registered manager said further adjustments would be made if needed. For example, one person had a picture on their door as a reminder of where their bedroom was. Signs around the home identified the purpose of a room for instance a toilet or bathroom. A few pictures around the house reflected the locality where people were living or prompted reminiscence about the war. Some activities promoted reminiscence or music which would appeal to people with living with dementia.

Occasionally people living with dementia became upset or anxious. Staff used their skills to distract and calm people but had recognised they needed further training to help them support people when in this state. A health professional confirmed this raising concerns about the ability of staff to cope with people with advanced dementia. The registered manager said referrals had been made to mental health teams for support and advice. She said incidents had significantly reduced as a result. Staff said there were fewer occasions when they were challenged by people's behaviour.

People or their legal representatives had given their consent to have their care and support delivered by staff. Some people had appointed a lasting power of attorney (LPA) to make decisions on their behalf for their health and welfare and/or their finances. A LPA is a legal agreement which allows a person to give authority to someone to make decisions on their behalf. The registered manager had checked these authorisations.

People's consent for their care and support was recorded in their care records. Staff sought people's consent before offering to help them. People were encouraged to make choices about the way they were supported. Staff had

Good

Is the service effective?

completed training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The registered manager described when decisions had been made in people's best interests. For one person an independent mental capacity advocate had been appointed to represent them and speak on their behalf.

Where people had been deprived of their liberty to keep them safe from potential harm the appropriate authorisations had been received. Deprivation of Liberty Safeguards (DoLS) provide legal protection for those people who are, or may become, deprived of their liberty. The registered manager was aware of changes in case law around DoLS and that additional DoLS authorisations needed to be submitted as a result. Wherever possible the least restrictive solution was found to keep people safe and to minimise restrictions. For example, instead of using bed rails to prevent people falling from their bed, high/low beds were provided with a mat on the floor to reduce the risk of injury.

People's nutritional needs had been assessed and where they were identified as being at risk of dehydration or malnutrition their care records clearly identified how they were to be supported. Their weight was monitored either weekly or monthly. A malnutrition tool was used to assess their individual risk. Food and fluid monitoring charts were completed to keep a record of their daily intake. The cook said all food was fortified using butter, cream and full fat milk. If people needed additional supplements these were prescribed by their GP. Where the GP had concerns about ongoing weight loss or the risk of choking they made a referral to a speech and language therapist. There were no people with any specific dietary requirements. The provider information return (PIR) stated catering staff would be attending dietary training days with a local training provider and their catering supplier.

People told us that food was "sensible - we don't get a lot of fancy stuff" and "food is very good". People were supported to eat their meals by staff if needed. Staff focussed on the person and gave them their food and drink at their pace, not rushing them. People were offered choices about what they had to eat and alternatives were offered to the main meal or if people didn't enjoy the meal they had chosen. One person liked to have a light lunch rather than a cooked meal. Snacks and fresh fruit were available around the home as well as cold drinks. Some people had drink making facilities in their rooms.

People were supported to keep well and stay healthy. Enhanced GP visits to the home were scheduled each week with additional appointments being made in emergencies. If people needed to see a dentist this was arranged with two local dentists. Chiropody appointments were scheduled for people. Community nurses and other health specialists attended people when needed. A health professional confirmed referrals were made to them appropriately. Some people had do not attempt resuscitation orders (DNAR) in place authorised by their GP and discussed with them, their legal representative or family. A visitor told us they had been very impressed with the sensitive way end of life discussions had been carried out.

Good

Is the service caring?

Our findings

People said they were happy with the care they received. Staff knew people's personal histories. Documents in their care records provided them with a summary of people's backgrounds. A summary of "This is Me" promoted by a national organisation was also used to describe people's likes, dislikes and routines important to them. Relatives confirmed they had been asked to bring in personal photographs and background information for these records. A relative said, "I feel very confident about their care - it's the little touches like 'I've saved you your favourite biscuit'. Sometimes I come in and she looks really lovely and staff say, 'I found this scarf in the wardrobe and then I found this jumper to go with it'". A health care professional said staff appeared to be "attentive and caring".

People used call bells to contact staff for help with personal care, if they were unwell or to collect meal trays. Staff used their knowledge of people to prioritise how they responded to call bells. When people were in pain or discomfort staff attended to their needs and if needed contacted health care professionals for advice and support. Staff showed concern for people's health and well-being during handovers and ensured all staff coming on duty knew about changes in people so they could respond appropriately. For example, one person had become unwell and staff were asked to give extra fluids.

People's spiritual and cultural beliefs were identified in their care plans. One person had received a visit from a spiritual leader of their faith. Other people were able to attend religious services at the home. People wishing to live together could be allocated two rooms to share.

Residents' meetings provided the chance for people to give feedback about their experience of the home. They talked about activities, meals and the laundry. People and their legal representatives discussed the planning and delivery of their care with staff. Relatives were encouraged to participate in this process if people wished them to be involved. People also had a key worker who spoke with them each month about their care needs. This was documented in their care records. Where people suggested changes in their care this would be entered on this record.

Each person had a copy of the service user guide setting out the service they could expect to receive. Information about how to access local advocacy services was displayed in the reception area. Other information about CTCH Limited and previous inspection reports were provided for people and visitors to read. Information about how to make a complaint was clearly displayed and people, their relatives and staff used the complaints process to provide feedback about the service. The provider information return (PIR) stated people's views were listened to and acted upon. For example menus and activities were changed to reflect people's personal preferences.

People were treated with dignity and respect. A person commented, "We get on ever so well - all of us. We're ever so friendly here. In all the time I've been here, I've never come across any of them who has been cross or niggly or anything." One relative told us, "It's very good - she's happy now. They treat her with respect. The carers here are lovely. They do seem caring." Staff discreetly prompted people with personal care or with help with eating and drinking. The PIR stated that in response to the annual survey, "Respondents felt that they were treated kindly and as individuals. All respondents felt that staff respected them and treated them with dignity." Staff had been given a copy of the code of conduct for health care support workers providing them with guidance about national expectations of how to treat people.

People were supported to be independent. Their care records identified what they could do for themselves and what they needed help with. For example, staff prompted people to feed themselves only helping them when they were struggling. People were encouraged to maintain their mobility using walking aids. One person told us, "I am always pleased to get up, I like to get up and get busy. I get myself dressed." A visitor said, "Staff helped [name] wash and dress when she came out of hospital but promoted independence at other times."

People had visitors whenever they wished. One person said their relative visited them daily staying with them in the lounge and other visitors chose whether to meet people in privacy or in shared areas. People also went out with visitors. Relatives said they had been invited to attend training events and the forthcoming 'Positively Caring Day' being held at the home. Two people told us they had been allowed to bring their cats to live with them in the home. One person said, "I'm very contented - once they brought Lanky (the cat) in, I settled down."

Good

Is the service caring?

People's information was stored securely and kept confidentially. Their care records were kept in a secure cabinet in the office which was locked when not in use. The PIR stated computers had been password locked to protect any personal information being kept electronically.

Requires Improvement

Is the service responsive?

Our findings

People's experience and involvement in social activities was inconsistent. People told us, "Sometimes I wish there was more to do", "We have to amuse ourselves" and "I fell asleep - boredom". A visitor commented, "[name] doesn't seem to get involved in activities. Staff might encourage her but Mum is likely just to say no". Staff made sure people's care needs were responded to but this meant they were not always able to spend social time with people. During mealtimes they were able to chat with some people catching up on news and their families. There were however long periods of time when people were sitting in their rooms or in the lounge asleep or dozing without any engagement or interaction with staff. Some people talked with each other or had visitors. One person commented to another person, "I really don't know what we are waiting for?" The sing along activity scheduled for the afternoon had been postponed although not everyone had been informed of this. Instead staff were giving some people manicures.

People were offered a schedule of activities. This was displayed in the hallway informing people about manicures, singalongs, films, knitting and bingo. These were however liable to be changed due to demands on staff or staff being re-allocated to other duties. There was no dedicated activities co-ordinator. The representative of the provider had noted in one of their monitoring visits the activities schedule included hair dressing and nail care which were part of people's on-going care routine. A small cinema showed films or television. One person liked to use this facility each day. Trips out were being planned and had been discussed with people at a resident's meeting. The provider information return (PIR) confirmed future plans included providing "personalised activities".

People's needs were assessed prior to moving into the home and their relatives confirmed they were part of this process. A relative told us the move into the home had been done slowly so the person could adapt to the changes. They had visited for lunch, then an overnight stay followed by a week's stay. This had worked well for them.

When people's needs had changed they and their legal representatives had been involved in a reassessment of their needs. For example, after a hospital stay a person's needs had been reassessed before going back to the home to see what they could still do for themselves.

People's care records reflected the care and support they wished to receive and the way in which they wanted this to be delivered. This was based on their history, preferences and routines important to them. They clearly stated what they could do for themselves and what they needed help with. For example, the moving and handling care plan for one person prompted staff to encourage the person to do transfers independently. When people's needs changed their care records were updated to make sure they received the appropriate care and support. Staff highlighted any changes in people's well-being during handover ensuring people continued to receive individualised care. A relative commented, "They're good about phoning me if they need to - if Mum's unwell, or they've called the doctor."

People with sensory or physical conditions had access to a range of equipment to help them to remain independent. Some information was displayed in easy to read formats using plain English and illustrated with pictures, or using larger font and pictures with a brightly coloured background. Staff were prompted to check people's hearing aids and glasses and encouraged people to use walking aids. A cordless telephone had been provided so people could take personal calls wherever they wished. A computer has been provided with access for people to make calls to family or friends.

People felt comfortable about raising concerns. A person said, "I think if you had any problem, the only person you'd speak to is the Manager." Visitors confirmed this and one commented, "We haven't any complaints at all. If I had any worries at all, I'd go to (the Manager)." A relative said they had raised a concern because their parent could no longer manage a cup and saucer and it was changed to a beaker. The PIR stated three complaints had been received and action had been taken to address the issues raised such as problems with the laundry and concerns about staff performance.

Good

Is the service well-led?

Our findings

People commented, “You can’t fault the care here” and “They’re (staff) all super”. People said they attended residents’ meetings and talked about the meals, activities and trips out. A relative told us they were able to attend residents’ meetings with the manager which they described as “worthwhile” but poorly attended. They said they tended to focus on the menu and after one meeting more fresh fruit had been provided. Each year people and their relatives were invited to respond to a survey about their experience of care. Last year’s survey (October 2014) had resulted in improvements to the service provided such as changes to the laundry. People and their relatives felt able to drop into the office to talk with the manager whenever they wished.

People’s well-being was being protected by staff who were confident about raising concerns and using the provider’s whistleblowing procedure. Issues raised by staff had been investigated and the appropriate action taken in response. Staff had the opportunity to attend staff meetings; two had been arranged this year. At one of these meetings they had discussed safeguarding in light of recent incidents and were asked to give suggestions for improving staff allocations and routines. Adjustments had been made to the way lunchtimes were managed.

When people had accidents or incidents records were maintained detailing what had happened and when. They identified what action had been taken to prevent further harm or risks to people such as referrals to health professionals or providing alarms or equipment. The registered manager monitored accidents and incidents to establish if any trends were developing and whether further action needed to be taken. Audits of accidents and incidents were also checked by a representative of the provider to make sure the necessary action had been taken.

Where poor performance of staff had been identified strategies were put in place to support them to reflect on their knowledge and skills. Through individual meetings, training or mentoring they were encouraged to improve. The provider information return stated, “Following any required immediate action supervision, both individual and group, is carried out to support those involved. Where necessary, individuals can be placed on the Performance Management Pathway.”

Parton House had a registered manager who was supported by a recently appointed deputy manager. A health care professional said she was “approachable” and “efficient”. The registered manager was aware of their responsibility in respect of notifying the Care Quality Commission about notifications and incidents affecting the well-being of people living in the home. The registered manager was supported by a representative of the provider. This support had been increased for a period of time to help review and update some of the processes and procedures operating within the home.

The registered manager met with other registered managers working for the provider to share and discuss best practice and changes in legislation and other guidance. The registered manager as a lead dementia worker also met with other providers to share their knowledge and practice. The provider had representatives who attended local networks and a providers’ association. Information and guidance from these was cascaded to the registered manager. Parton House was being used to host a 'Positively Caring' day in May 2015. This was organised by C.T.C.H. Limited with input from the National Health Service, Care Home Support Team and Alzheimer's Society.

As part of their quality assurance process a representative of the provider visited the home and completed audits covering the fundamental standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where actions were identified there was a clear record of when these had been completed and evidence they had been followed up. For example scheduling weekend activities into the activity schedule. The representative of the provider said on going failure to comply with these actions would lead to performance management. Audits were being completed to check on the safety of the environment, medicines administration, care planning records and staff training. There was evidence servicing of equipment and systems were being carried out at appropriate intervals.

The provider’s website stated their values for the organisation were that, “All staff believe that every person is an individual and as such is unique. All staff acknowledge that residents have the right to expect a high standard of care, delivered by safe, competent team members.” The registered manager said they aimed to “build confidence of new staff through training to recognise this is the residents’ home and to promote a homely environment and

Good

Is the service well-led?

independence." The representative of the provider said they wanted to "get everyone working to the same standard - high standards not the minimum standards." These values were embedded in staff training and individual meetings. A member of staff said, "We give the best care we can, staff are very hard working."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with care and treatment being provided safely. People were being moved using unsafe moving and handling procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed People who use services were not protected against the risks of employing unfit or proper persons. Where persons had previously worked with children or adults the reason for leaving that employment had not been checked.Regulation