Park View Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 27 February 2017 and was unannounced.

At the last inspection on 6 June 2016 we rated the service Requires Improvement and there were no regulatory breaches.

Park View Nursing Home provides accommodation and nursing care for up to 43 older people. There were 26 people living at the home when we visited. Accommodation is provided over two floors with lift access between the floors. There are communal lounges and a dining room as well as toilets and bathroom facilities. A kitchen and laundry are located on the ground floor.

A manager is in post whose application for registration is being processed by the Care Quality Commission. 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.

Generally we found the improvements made at the last inspection had been maintained. However, we identified inconsistencies in record keeping, the management of risk and monitoring of nutritional needs.

People told us they felt safe in the home and we found there were enough staff to meet people's needs and keep them safe. The home has experienced ongoing difficulties in recruiting permanent nurses and has used regular agency nurses to ensure continuity of care. Three permanent nurses were due to start work at the home in coming weeks once all employment checks had been completed. Recruitment processes ensured new staff were suitable to work in the care service.

Staff knew about the different types of abuse and the signs to look for that may indicate abuse was occurring. They were aware of reporting systems and knew about the whistleblowing procedures. We saw safeguarding incidents had been dealt with and reported appropriately to the relevant agencies.

We had concerns about how risks were assessed, monitored and managed in relation to individuals and the environment. For example, we found a lack of information and consistency around the management of blood sugar monitoring where people had diabetes. Our tour of the building also found risks related to unguarded radiators and wardrobes which were not secured posing a risk of them being pulled over. These issues had not been identified or resolved through the home's own daily checks.

Systems were in place to ensure staff received the training and support they required to carry out their roles. However, we found some staff were overdue refresher training in some areas and some staff supervisions were behind. The manager was aware of this and had a plan in place to address these issues.

People told us they liked the food and we saw they were provided with a varied choice of different meals and drinks throughout the day and at night if required. However, people's nutritional needs were not always monitored effectively and consistently. For example, we found food and fluid charts were not always completed correctly or reviewed and monitored.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People told us they received their medicines when they needed them and overall there were good systems in place. However, we found the recording of creams applied by care staff needed to improve.

People and relatives praised the staff who they described as kind and caring. We saw staff treated people with respect and ensured their privacy and dignity was maintained. People knew how to make a complaint and records showed complaints were taken seriously and dealt with according to the complaints procedure.

People told us they enjoyed the activities and we saw people had a good time playing bingo. However, we recommended further support was sought to make sure people's faith needs were met.

Quality assurance systems were in place and staff and people who used the service spoke highly of the manager. However, we saw the lack of a permanent nursing team to support and assist in ensuring consistent leadership, increased the burden on the manager. This had resulted in things either not being done or not followed up when the manager had recently been absent through illness. These issues were now being addressed following the manager's return and the pending employment of permanent nurses provided further assurance of continued improvements.

We found two breaches of regulation. These related to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Overall safe systems were in place to manage medicines which ensured people received their medicines as prescribed.

There were enough staff to support people safely and meet their needs. Staff recruitment processes ensured staff were suitable to work in the care service.

Staff understood safeguarding procedures and incidents were reported appropriately

The premises were clean and there was an ongoing refurbishment programme. The building was generally well maintained, although some maintenance issues had not been identified or resolved through the home's daily checks. Risks to people's health, safety and welfare were not always fully assessed and mitigated.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received the training and support they required to fulfil their roles and meet people's needs. Refresher training and supervision for some staff was overdue however the manager had plans in place to address this.

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People enjoyed the food and were provided with a varied, choice of meals and drinks. However, improvements were required in the recording and monitoring of people's nutritional needs.

People had access to a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People and relatives praised the staff and described them as kind and caring.

People's privacy and dignity was respected and maintained by staff.

We recommended improvements in meeting people's faith needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although staff knew people's needs well, the care records varied in the amount of detail recorded about the support people needed and their preferences.

People were provided with group and individual activities in-house as well as visits from entertainers. We saw people enjoying activities on the day of the inspection.

A system was in place to record, investigate and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

Overall the service had maintained the improvements made at the last inspection and there was consistent leadership and management. However, some shortfalls were identified in relation to record keeping and risk management. The manager's registration application to the Care Quality Commission is being processed.

Park View Nursing Home Limited

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 27 February 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience with experience of services for older people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams and the clinical commissioning group (CCG).

We usually ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we did not request a PIR on this occasion.

We spent time observing the care and support delivered in communal areas. We spoke with 12 people who were living in the home, one visitor, three care staff, one nurse, the cook, the manager and the provider.

We looked at four people's care records in detail and others to follow up on specific information, four staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were in place which identified areas of potential risk to people's general health and welfare such as mobility, nutrition, medication and skin care. We saw some risk assessments and care plans did not contain sufficient detail which led to inconsistent practices. For example, we looked at two people's care records. Both people were diabetic and required their blood sugars testing on a daily basis; however, we found the care plans did not contain sufficient information. For example, there was no information about the normal blood sugar level for each person. For one person there was information about the symptoms of low blood sugar levels and the action to take if this occurred, but no information about what to do if blood sugar levels were high. We saw there were inconsistencies in the actions staff had taken in response to different blood sugar results and identified a lack of oversight and monitoring of people's blood sugar levels. We saw inconsistencies in where staff recorded the blood sugar test results within people's care records. This meant it was difficult to get an overview of the levels recorded. The records showed a number of occasions where people who required their blood sugars to be tested twice a day, had only had them checked once a day. This had not been identified and addressed. We raised this with the manager who told us they would take action to address this matter.

The provider told us there was an ongoing programme of refurbishment and redecoration throughout the home and we saw evidence of this in some of the bedrooms and communal areas, which were light, bright and comfortable. However, our tour of the building identified a number of maintenance issues which required attention and which had not been identified or resolved through the home's own environmental audits. For example, in one occupied bedroom we found the radiators in the room and ensuite were unguarded and the surface temperatures were very hot. We found the same in the dining room where one radiator, next to tables where people were sat, was unguarded and very hot to touch. This put people at potential risk of burns from hot surfaces. We found free-standing wardrobes in some rooms had not been secured to the wall and there was a risk these could be pulled over by people. In two bedrooms we saw large televisions were balanced on small chests of drawers again posing a risk to people if they were knocked over. Although the maintenance person took immediate action to address these matters when we brought them to their attention, these issues had not been picked up through their daily environmental checks.

We concluded risks to people were not always assessed, monitored and mitigated to keep people safe. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a range of checks were undertaken on the premises and equipment to help keep people safe and the records showed these were kept up to date. These included checks on the fire, electrical, water and gas systems, the passenger lift and lifting equipment.

People we spoke with told us they felt safe and said if they had any concerns they felt able to go to staff to discuss them. One person said, "Oh, I feel safe and happy here, definitely." Another person said, "Yes, I feel safe here and I like the staff and I feel at home." A further person said, "I feel safe here and could speak to any of the staff about any issue."

Systems were in place which ensured safeguarding incidents were recognised, reported and dealt with appropriately. Staff we spoke with confirmed they had received safeguarding training and knew how to recognise and report any suspicions of abuse and were also aware of whistleblowing procedures. Safeguarding records we reviewed showed incidents had been investigated and action had been taken to ensure people were protected. We saw appropriate referrals had been made to the Local Authority safeguarding team and we had been notified about safeguarding incidents as required.

Our observations throughout the day showed there were enough staff on duty to make sure people were safe and received the care and support they needed in a timely way. This was confirmed by our review of the duty rotas and our conversations with staff, people and a visitor. Comments made by people included; "They respond to my buzzer right away" and "They do come quickly at night. I've been told to buzz them if I need anything at all" and "There seem to be enough staff around when I need them" and "(Staff) always come to assist me when needed."

The manager told us the usual staffing levels were one nurse and seven care staff on duty from 7.30am to 7.30pm and one nurse and three care staff from 7.30pm to 7.30am. In addition there were ancillary staff such as an activities coordinator, maintenance worker, chef, kitchen assistant and domestic and laundry assistant. The manager worked Monday to Friday but said as they lived nearby they also came in at the weekend to check if staff had any issues. The staff were given the manager's mobile number so they could call them in the event of an emergency or if they had any concerns.

The manager and provider explained the ongoing difficulties they had experienced in recruiting permanent nurses and at the time of the inspection the manager was the only permanent nurse. All other nursing support was provided by agency staff. We saw the same agency nurses were used to ensure consistency in the support provided. The manager also confirmed three permanent nurses had been recruited and were due to start when the relevant employment checks had been completed.

Safe recruitment procedures were in place and we reviewed documentation relating to recently recruited staff. Staff had completed an application form which detailed the applicant's employment history and qualifications. References had been received before staff commenced in post, including a reference from the applicant's last employer. We identified the date of employment on one individual's application form was different to the date on their reference, which meant there was a gap of five weeks which had not been accounted for. The manager said they were unaware of this but would investigate it and implement additional checks to ensure it did not happen again. Detailed interview records and proof of identity documents were kept on file and criminal record checks had been obtained from the Disclosure and Barring Service (DBS) prior to staff commencing work. Systems were in place to ensure nurses had valid and current registration with the Nursing and Midwifery Council (NMC). Overall we concluded that appropriate checks were in place to ensure staff were suitable to work at the service.

People told us they received their medicines when they needed them. One person said, "They certainly give me my medicines at the right time and everything's fine in that regard." Another person told us, "I do get my medication daily and would speak to the manager if there was any concern. I was having difficulty in swallowing two large tablets and the staff got the prescription changed, so that I'm now able to swallow smaller alternative tablets."

People's medicines were stored securely in individual medicine cupboards in their bedrooms along with their medicine administration records (MARs). Some medicines were kept in the treatment room and the temperatures of the storage areas, including the medicines fridge, were checked to make sure they were within the recommended limits.

We checked a sample of people's MARs and found these were generally well completed. There were suitable arrangements in place to make sure medicines which were prescribed to be taken at a specific time in relation to food were given correctly and protocols were in place to guide staff in the administration of 'as required' medicines. We checked the stock of medicines for one person with the nurse and found these balanced with the levels recorded on the MAR.

However, we found inconsistencies in the MARs which care staff completed to show they had applied prescribed creams as there were some gaps where staff had not signed the MAR. From speaking to staff and people who used the service we were assured creams were being applied, however, the records did not always reflect this. We discussed this with the manager who was already aware of this as it had been identified in a medicine audit and action was being taken to resolve this matter.

Some medicines are classified as controlled drugs because there are particular rules about how they are stored and administered. We checked the storage, the records and a random selection of stock and found they were correct. We saw weekly balance audits of controlled drugs had been recorded but had lapsed since December 2016. However, the nurse showed us the new recording sheet which the manager had put in place to start that week. Overall we concluded that safe systems were in place to ensure people received their medicines safely and appropriately.

Requires Improvement

Is the service effective?

Our findings

The manager told us the majority of training was done online with staff completing an assessment which was marked by the external training provider and checked by the manager. If staff scored less than 80% they completed the module again and had additional supervisions to ensure they were competent. There were no regular ongoing checks of individual competency to ensure staff understood what they had learnt, although the manager said they had plans to include testing staff on 'hot topics' during individual supervisions. They said they currently did this during staff meetings, however recognised these were collective discussions, rather than assessing each individual staff member's competence.

We reviewed the training matrix and saw areas where training updates were required. For example, 70% of staff required an update in health and safety training, 50% in safeguarding and 46% in moving and handling. The manager showed us a plan they had in place to address this with individual staff. They said where staff had not completed the relevant training they would implement the provider's disciplinary procedures.

The manager completed an induction checklist when agency workers first started at the home to ensure they had the appropriate training and skills to care for people. This included the fire safety procedures and how to complete the electronic care records. We spoke with an agency nurse who had worked at the home for three months and they confirmed their induction had been thorough and had included these areas.

The manager told us all new staff completed comprehensive induction training and shadowed a more experienced staff member until they felt confident and competent to carry out their roles effectively and unsupervised. We saw systems were in place to check and review new staff's progress and competency at regular intervals throughout their probationary period. The manager explained they were looking at introducing the care certificate in the future. The Care Certificate is a nationally recognised study plan for people new to care to ensure they receive a broad range of training and support.

The manager said staff had supervision every three months and an annual appraisal. We reviewed the supervision tracker which showed some staff had not received supervision for over five months. The manager explained the tracker was not up to date and said they had fallen behind with staff supervisions due to being off ill. As the only permanent nurse working in the home the manager currently carried out all staff supervisions. They had a plan in place to ensure all staff had received supervision by the end of April 2017. Staff records we reviewed showed supervisions were used as an opportunity to discuss any concerns and development needs. We concluded supervisions could be more actively used to test individual staff member's knowledge of key topics.

People told us they liked the food and said they could choose where to have their meals. One person said, "The meals are quite good. I take all my meals up here now (in their room)." Another person said, "The food is very good here. They will get me special things occasionally, such as salmon." A further person said, "I don't need any support with my meals, which are home-cooked and good." A relative of a person who was diabetic told us, "In the last care home, my (relative) was not allowed to eat any desserts. It seemed unfair. At least here she can have small portions, which keep her happy."

We saw breakfast was a relaxed affair where people came into the dining room throughout the morning. Upon their arrival each person was provided with a drink of their choice and asked their preference for breakfast, which was promptly provided. We saw people were offered a choice of cereals, toast with various preserves and the hot breakfast option was fried eggs on toast. The cook told us the hot breakfast option changed daily and if people wanted something specific making for any meal they just had to ask. During the morning people were asked what they would like for lunch with two choices offered for both the main meal and dessert. The cook said they made extra portions of each meal in case people changed their mind or there were visitors who wanted to have lunch. They also said specific requests were catered for if people fancied something that wasn't on the menu.

Tables were laid with clean table cloths, napkins and condiments for people to help themselves to such as salt, pepper and vinegar. Lunch looked hot and appetizing. A gravy jug was brought to the table so people could specify how much they wanted and they were offered extra butter to add to their mashed potato. Where people required support to eat their meals we saw this was done in a relaxed and personalised manner.

Our discussions with people and the cook, our review of menus and observations led us to conclude that people were provided with a varied and balanced diet. The cook knew people's dietary needs and preferences and this information was also available in the kitchen for them to refer back to at any time. Homemade puddings were freshly made each day. However, this did not always include a diabetic option. The cook showed us the powdered sweetener and said they had made low sugar puddings in the past. We raised this with the manager who said they would ensure the cook included more variety in the menus for people living with diabetes.

Improvements were needed to the management of nutritional risk. For example, one person had been refusing to eat and was losing weight. They had been prescribed dietary supplements but records showed they were regularly refusing to drink them. Whilst the person's care records identified they were at risk of malnutrition and dehydration, there was no information about what measures had been put in place to monitor their dietary intake and whether they required additional assistance during mealtimes. Our observations showed the person was able to eat independently, but they would have benefitted from additional encouragement, prompting and monitoring from staff at mealtimes. During lunch we saw staff did not stay with them to monitor how much they had eaten. They ate two mouthfuls of mashed potato and then pushed their plate away. The plate was taken without any encouragement to eat more and the person was not asked if they would prefer something else to eat instead and the same thing happened with dessert. The person's care plan stated staff should explain to them the implications of refusing food, but we did not see staff do this at lunchtime. Staff told us this person would often spit out food and drinks, although this was not recorded in their care plan. We saw this happened at lunchtime and staff were not present to witness this so were unable to accurately record how much food and drink the person had actually consumed. The care records showed whilst they had been refusing most meals they would often have a glass of milk. We discussed this with the cook who was aware the person had not been eating meals but had not looked at ways in which additional calories could be given such as making high calorie milkshakes. The manager explained they had been trying to get this person's GP to visit them. The person had been seen by the QUEST Matron in recent weeks regarding their weight loss. The manager said they would make another request to the person's GP for a review and would send additional information to the GP to evidence the increased risk of malnutrition and dehydration.

Nutritional risk assessments were completed on admission and people's weight was monitored. We reviewed the records of two people who were nutritionally at risk. In both cases improvements were required to how food and fluid intakes were recorded and monitored. For example, fluid intake records were

not consistently completed and showed people regularly did not consume the recommended daily fluid intake levels. We also saw where people had refused meals or only consumed a small amount of food, it was not always clear what action staff had taken to respond, such as offering additional meals or snacks outside of mealtimes. We concluded these shortfalls demonstrated a lack of effective governance and as such were a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff we spoke with said they had received training in MCA and DoLS and we saw a procedural flowchart for DoLS was displayed in the staff room. Staff were aware which people had authorisations in place and this information was readily available to staff on the noticeboard in the staff room. At the time of our inspection six people had DoLS authorisations in place and three DoLS applications were awaiting approval. We looked at one person's records and found the conditions which were associated with the authorisation were being met. The manager and nurse confirmed no people were having their medicines covertly.

People told us staff sought their consent before carrying out any care and support and we saw this happening in practice. One person said, "They always ask my permission before taking any action." Another person told us, "They always ask for my consent before doing anything."

We asked people if their healthcare needs were being met. One person told us, "They will get a GP for me if needed." Another person said, "I haven't seen the GP, but I have recently seen an optician as my eyes are quite sore at the moment and I am currently using drops for the condition." A further person said, "I've asked to see the optician because my eyes are watering and I'm not seeing as well as usual. I do wear glasses for reading, so it will be a good chance to have my prescription checked. I was last in hospital about two weeks ago and was glad to get back here after three days in there." Care records showed people had been seen by a range of health care professionals including GPs, community matrons, district nurses, specialist nurses, dieticians, opticians and podiatrists. This demonstrated people's health care needs were being met.

Good

Is the service caring?

Our findings

People spoke highly of the staff and described them as kind and caring. One person said, "I think the staff are kind. I'll let them know if I need anything and they listen to me." Another person said, "All the staff seem very caring." A further person told us, "Everything's very good here, the girls are lovely." Another person told us, "Staff are kind here. We're treated well." A relative we spoke with said, "The family are happy with the level of care here. The staff are kind and caring."

People told us they liked the home and were happy with the accommodation. One person told us how much they liked their room and said, "Although this room is small, it's cleaned and dusted daily. They asked me if I wanted to have a larger room, but I like the view across the park from this room." Another person said, "I am happy here and feel safe. People respect my choices and always come to assist me when needed. I have a buzzer in my room. I like my room - it's clean and I have bits of my own in there." A further person told us, "I like the environment in here. It is very good with the road below and the park nearby too. I can look out of my window and see what's going on."

We saw staff were patient and kind with people and enabled them to do things at their own pace. For example, we saw a staff member accompanied one person, who was using a walking frame, on the way to the dining area from their bedroom on the ground floor. Although this took some time, the staff member was patient and encouraging. At lunchtime we saw another staff member brought a person their lunch in the lounge. The meal was brought in on a tray and the staff member asked the person if they would like gravy and extra butter on their potatoes. They told the person what the meal was and asked if they wanted their food cutting up. All this took some time but the staff member was patient and gave the person time to respond. We heard the person say, "This looks lovely. Thank you" and the staff member replied, "I hope you enjoy it."

We found staff knew people well and had developed meaningful relationships with the people they supported. We saw care staff approached people in a way which showed they knew the person well and how best to assist them. For example, we saw one person was becoming anxious during the morning. We saw staff engaged the person in a topic of conversation which was relevant to their past and this person soon became calm and was laughing and joking with staff.

People told us staff treated them with respect and maintained their dignity. One person said, "They respect my dignity. They always knock at my door before coming in." Another person said, "Respect is shown." A further person said, "The carers here are kind and respectful. They respect my privacy." We observed staff knocked on people's doors before entering rooms. People looked comfortable and were well dressed and clean which showed staff took time to assist them with their personal care needs and made sure their dignity was maintained. We saw people who remained in bed in their rooms looked comfortable and had their call bell and drinks to hand. We saw information on the wall in the dining room and main corridor from the Dignity Council which detailed best practice on ensuring people were cared for with dignity.

We saw people were regularly offered choices so that they could make informed decisions about the care

and support they received. For example, the morning drinks trolley had a selection of drinks, biscuits and fruit. People were shown the options available to them so they could select which drink and snack they wanted. We saw a menu board with pictures of the food on offer for the day displayed. We saw staff show people the pictures when helping them to choose the foods they wanted to eat. This showed us staff were mindful to use alternative communication techniques to ensure people living with dementia could express their views.

Some people we met spoke with us about their different faith and religious beliefs which had clearly been a significant part of their lives. One person had been involved with the Salvation Army and two others were Catholics. We asked staff how people's faith needs were met and they told us a vicar used to visit regularly from the local church but said this had not happened for a while. They were not aware of any other arrangements in place to provide people with support to meet their faith needs either in the home or outside in the community. During the day we saw one person was enjoying chatting to two visitors from the Methodist church they used to attend before they were admitted to Park View Nursing Home. However, this was not something which had been organised by the home. The person told us, "I do enjoy having visits. My family come to see me, as well as friends from the church. I used to read lessons at church, you know. I love reading and singing whenever I can."

We recommend that the service seeks advice and guidance from a reputable source about supporting people and involving them in decisions about meeting their cultural and faith needs.

Requires Improvement

Is the service responsive?

Our findings

The home used an electronic care recording system. We saw the level of detail and personalised information within people's care records varied. For example, some records had detailed and personalised information about people's life and social history, whereas others did not. We raised this with the manager as we were concerned that with the impending arrival of new staff the quality of information within care records needed to be consistent. The manager told us they had already identified this issue and were in the process of updating all care records to ensure they contained sufficient detail.

Care staff we spoke with told us each staff member was allocated a number of people whose food and fluid intake they monitored throughout their shift. They showed us the notebooks they carried with them where they recorded people's food and fluid intake throughout the day and said this information was then transferred onto the electronic records before the end of their shift. We saw this meant there was sometimes a delay in staff completing the electronic daily notes. For example, the daily notes for one person showed information relating to what they had eaten for breakfast on 25 February 2017 had been entered at 15.54. The entry made showed they had not eaten anything for breakfast. The only other entry relating to their diet was made at 19.06 and stated, 'Declined dinner today, despite being offered encouragement and alternatives by staff'. This person was at a high risk of malnutrition and was losing weight. It was therefore important that their dietary intake was closely monitored. The delay in entering this information presented a risk that appropriate action may not have been taken in response to this.

Our observations showed staff knew people well and engaged people in topics of conversation which were of interest to them. For example, we saw staff speaking with one person about their family and previous job, which we saw the person responded to positively.

People we met spoke with us about the activities they enjoyed taking part in at the home. One person said, "I like some of the activities, for example bingo, singing and I love to knit, but I haven't done any knitting for a while." Another person said, "I don't mind joining in with activities, especially singing and dancing when I can." A further person said, "I like some of the activities, such as singing. I used to be a tribute singer and sang in local clubs and pubs. I won a big singing competition in Blackpool once."

We saw information in people's care records which outlined the types of social activities they enjoyed. For example, we saw one person's care plan showed they did not enjoy group activities, unless it was something therapeutic, but preferred individual one to one activities. There was also detailed information about their life history to assist staff in engaging them in individualised conversation on topics which were of interest to them.

A staff member who had previously worked in the kitchen had become the new activities coordinator. It was their first day in this role on the day of our inspection. The manager discussed how they were going to support them to develop a personalised and varied activities programme which focused on the needs and preferences of people who used the service and would use the information within care records to assist them with this.

We saw an events planner advertised in the entrance of the home above the signing in book. This showed the various entertainment events which were taking place over the next two weeks so that visitors could also attend if they wished. This included musicians, singers, Zumba classes and 'active minds' which were activity and stimulation therapists who held specialised events such as quizzes and reminiscent events.

During the afternoon of our inspection we saw the activity coordinator leading a bingo session in the lounge with several people. We saw people were fully engaged and were laughing and having fun and enjoyed winning sweets and chocolate bars. We saw other staff were present and supported people so they were able to take part in the session.

People we spoke with told us they knew how to make a complaint and would raise any concerns with the staff or manager. One person said, "I feel happy and safe here and would complain to the manager, if needed." Another person said, "I could speak to any of the staff about any issue."

The complaints procedure was displayed in the home and complaints/concerns and suggestion forms were freely available in the reception area. The manager told us one complaint had been received since the last inspection. Records showed this had been investigated and a written response had been sent to the complainant. We concluded the systems in place to manage complaints were effective.

Requires Improvement

Is the service well-led?

Our findings

The improvements we had found at the previous inspection in June 2016 had generally been maintained. However, both the provider and the manager had had recent periods of absence due to illness and this had impacted on the progress made in developing improvements. The manager acknowledged that, as the only permanent nurse employed in the home, some things had slipped while they had been absent as they had not been around to either do the tasks themselves or check that other staff had completed them. We saw evidence of this in the gaps in some of the care records, the inconsistencies around risk management and incomplete food and fluid charts. The manager was confident this situation would improve with the pending employment of three permanent nurses who, when in post, would provide additional support, leadership and oversight to the staff team. Since the last inspection two of the care staff had been appointed to senior roles following further training and these roles also provided additional support to the manager and staff team.

Systems to assess and monitor the quality of the service were in place which included regular audits in areas such as medicines, weights, infection control, environment, equipment and care plans. Some of these audits were completed by an external consultant to assist the manager and provide independent oversight. We reviewed a sample of audits and found these were detailed and listed any actions that needed to be taken.

However, we also saw some audits were not effective such as the daily checks of the environment as issues we identified had not been picked up or resolved. We looked at the weight audits and saw a number of gaps in the weights recorded in November and December 2016 and January 2017. The manager explained they had given individual staff members responsibility for ensuring people were weighed regularly. However they identified staff had not been doing this correctly so the manager had taken back the monitoring of people's weights. We saw this resulted in more consistent records being kept.

We concluded governance systems were not sufficiently robust to ensure the continued smooth running of the service in the manager's absence. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had submitted an application to register with the Care Quality Commission and this was being processed.

People, staff and a relative we spoke with during the inspection praised the management of the service. Staff told us they enjoyed working in the home and felt supported by the manager. One staff member said, "(The manager) is brilliant, she's stern but approachable." They said they were encouraged to make suggestions as to how the service could be improved and felt their views were listened to and considered. All the staff we spoke with said they would recommend the home as a place to work and would also be happy for a relative of theirs to be cared for in the home.

Some people we spoke with knew the manager, others said they did not. One person said, "I like the

manager. I think she knows me well and I think that she is approachable." Another person said, "I'm not sure that I know the manager, but I'm sure she's as nice as everyone else is here."

A relative we spoke with praised the manager. They said, "The manager is really nice and very approachable. She made sure that everything was as familiar as possible when my (relative) was being transferred here. For example, the photographs of the family, which are so important to my (relative), were up on the walls of her room before she arrived.'

We found required notifications such as serious injuries and allegations of abuse had been reported to the Commission. This helped us to monitor events which occurred within the service.

We saw the rating for the service from the last inspection report was displayed in the home as required and on the provider's website.

Electronic care records demonstrated incidents and accidents were reported and preventative action taken to help prevent a re-occurrence. We saw accidents and incidents were being analysed and action was being taken to mitigate identified risks.

Staff meetings were held every two months. Our review of the minutes from the last two meetings showed that a variety of topics were discussed to ensure staff were kept informed of key changes and developments.

We saw satisfaction surveys had been sent out to people and relatives in July and August 2016. Fourteen surveys had been received back and we saw the feedback showed overall satisfaction with the service. Comments made by one person stated, "Very satisfied with everything in the home. Everyone is really good towards residents and also people who visit." A relative had commented, "Very happy with this service, have complete peace of mind about mother's wellbeing." We asked the provider how people and relatives were provided with feedback about the surveys and they told us these were discussed at residents meetings. The manager said they would look at other ways in which they could collate the information and present it so people who were not able to attend the residents meetings were made aware of the findings.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way in relation to assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. A complete and accurate record of each service users care and treatment was not in place. Regulation 17 (1) (2) (a) (b)