Charing Gardens Limited

Park View Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out over two days on 5 and 9 January 2017. On 5 January the inspection was unannounced. We returned to complete the inspection on the 9 January 2017, this visit was announced.

The home provided accommodation and personal care for up to 44 older people who are living with dementia. The accommodation was provided over two floors and in a linked detached eight bedroomed annex. The accommodation was spacious and modern. Four of the bedrooms in the annex were double rooms. A lift was available to take people between floors. There were 33 people living in the home when we inspected.

There had not been a registered manager employed at the home since 17 February 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run. The provider was still in the process of recruiting a suitable manager and had kept us informed of the recruitment process they had undertaken. In the absence of a registered manager the provider's director of care and operations was in day-to-day charge of the home.

At the previous inspection on 4 December 2015, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to the deployment of staff and the recruitment of staff. The provider sent us an action plan telling us what steps they would be taking to remedy the breaches in the Regulations we had identified. At this inspection we checked they had implemented the changes.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice. The director of care and operations understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

At the time of this inspection there were only four people living in the annex. Since our last inspection, the provider had implemented a system of staff management in the annex, which ensured there was at least one member of staff in the annex at all times. People's experience of home had been affected by the changes to the managers, especially around staffing levels. The provider had taken action to address this and was recruiting to vacant staff posts. There were systems in place to assess the people's needs and areas of risk. However, it was not clear how this information was used to deploy staff in the right numbers, places and times in the home to meet those needs. We have made a recommendation about this.

Activities, both group and individual were available to people, but there was not a suitably qualified and experienced activities co-ordinator in post who understood how to plan activities for people living with

dementia. We have made a recommendation about this.

Recruitment policies were in place and now included information about any gaps in employment candidates for jobs may have. The recruitment policy reflected best practice and the law in relation to pre-employment checks.

People felt safe and staff understood their responsibilities to protect people living with dementia. Staff had received training about protecting people from abuse. The management team had access to and understood the safeguarding policies of the local authority, and followed the safeguarding processes.

The director of care and operations and care staff used their experience and knowledge of people's needs to assess how they planned people's care to maintain their safety, health and wellbeing. Risks were assessed and management plans implemented by staff to protect people from harm.

There were policies and a procedure in place for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely.

People had access to GPs and their health and wellbeing was supported by referrals and access to medical care if they became unwell.

People and their relatives described a home that was welcoming and friendly. Staff provided friendly compassionate care and support. People were encouraged to get involved in how their care was planned and delivered.

Staff upheld people's right to choose who was involved in their care, and people's right to do things for themselves was respected.

The director of care and operations involved people in planning their care by assessing their needs when they first moved in. People were asked if they were happy with the care they received. Staff knew people well and people had been asked about who they were and about their life experiences. This helped staff deliver care to people as individuals.

Incidents and accidents were recorded and checked by the manager to see what steps could be taken to prevent these happening again. The risk in the home was assessed and the steps to be taken to minimise them were understood by staff.

Managers ensured that they had planned for foreseeable emergencies, so that should they happen people's care needs would continue to be met. The premises and equipment in the home were well maintained.

Staff understood the challenges people faced and supported people to maintain their health by ensuring people had enough to eat and drink.

If people complained they were listened to and the manager made changes or suggested solutions that people were happy with. The actions taken were fed back to people.

People felt that the home was well led. They told us that managers were approachable and listened to their views. The director of care and operations of the home and other senior managers provided good leadership. The provider and the director of care and operations developed business plans to improve the home.

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.

Staff knew what they should do to identify and raise safeguarding concerns.

There were sufficient staff to meet people's needs. There were safe recruitment procedures.

Medicines were managed and administered safely.

Incidents and accidents were recorded and monitored to reduce risk.

The premises and equipment were maintained to protect people from harm and minimise the risk of accidents.

Is the service effective?

Good

The service was effective.

People were cared for by staff who knew their needs well. Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance. Staff received an induction and on-going training.

The Mental Capacity Act and Deprivation of Liberty Safeguards were followed.

Is the service caring?

Good

The service was caring.

People had forged good relationships with staff so that they were comfortable and felt well treated. People were treated as individuals and able to make choices about their care.

People had been involved in planning their care and their views were taken into account.

Staff protected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on assessments and the development of a care plan about them.

Activities were being developed based on people's needs.

Information about people was kept updated. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about.

Is the service well-led?

Good

The service was well led.

There were clear structures in place to audit, monitor and review the risks that may present themselves.

The providers promoted person centred values within the home. People were asked their views about the quality of all aspects of the care they received.

Staff were informed and enthusiastic about delivering quality care. They were supported to do this on a day-to-day basis by managers and senior staff in the home.

Park View Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the home, and to provide a rating for the home under the Care Act 2014.

This inspection took place on 5 and 9 January 2017. The first day of the inspection was unannounced and the second day was announced. The inspection team consisted of one inspector, a specialist advisor with a social work background and an expert by experience. The expert-by-experience had a background in caring for elderly people.

We looked at the provider's action plan, previous inspection reports and notifications about important events that had taken place at the home, which the provider is required to tell us about by law.

Not all of the people at Parkview were able to tell us about their experiences. Therefore, we spent time observing the care in communal areas. We observed how staff communicated with people so that we could understand people's experiences.

We spoke with 19 people and eight relatives about their experience of the home. We spoke with fifteen staff including the director of care and operations, the head of care, four senior care workers, seven care workers and two kitchen assistants. After the inspection, we received further information from the director of care and operations about medicines, audits and collated information about events that had occurred in the home. For example, the numbers of safeguarding referrals that had been made in 2016. We asked for feedback from a health and social care professional involved in planning care in the home.

We spent time looking at records, policies and procedures, complaint and incident and accident monitoring systems. We looked at seven people's care files, eight staff record files, the staff training programme, the staff rota and medicine records.

Good

Is the service safe?

Our findings

At our inspection on 4 December 2015, we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18, staff were not always available to supervise people in the annex and Regulation 19, staff had not always provided full employment histories before they were employed at the home.

At this inspection, we found the provider had made improvements to the way staff were recruited and in how staff were deployed in the annex. This meant that people were not left unsupervised.

People described a home that was safe. People said, "I feel safe living here because I know there is someone to call on if I need something."

Relatives told us that they felt that their family members were safe and secure. One relative said, "I am very happy with the home. My mother is well cared for and I never have to worry about her." Another relative said, "I visit every day and have never seen anything untoward."

The numbers of people living in the home was lower than it was at the last inspection. At our inspection in December 2015, there were 42 people living in the home, at this inspection there were 33. In addition to the director of care and operations and the head of care, there were six care staff including two senior care workers available to deliver care between 7 am and 9 pm. At night there were four staff delivering care including a senior care worker. Staff were deployed to areas of the home using a shift planner, and staff were deployed to the annex and main home by the head of care; this was reviewed every day. Additional staff were provided to assist with people receiving drinks and snacks and at meal times. Cleaning, maintenance, cooking and organising activities were carried out by other staff so that staff employed in delivering care were always available to people.

During this inspection we received mixed feedback from some staff and relatives about whether there were enough staff to meet people's needs. We checked some of the information in more detail on day two of our inspection. It was clear that there had been a period of staffing issues that affected the home in the run up to our inspection. In response to these issues, the director of care and operations had taken over the day-to-day management of the home. They had recruited to vacant staffing posts, were recruiting a new manager and there was already a proportion of new staff working in the home. This meant that the recent pressures on staffing levels reported by relatives and staff were being addressed to improve people's experiences. However, during the inspection, on the first floor, when two staff were delivering care to people in their bedrooms, there were periods of time where no staff were accessible to other people. Others reported they experienced long waits for staff to attend to their needs. One relative said, "My mum requires two staff to hoist her or change her in bed. She always has to wait. When it is lunch time, she can be waiting for up to two hours."

In discussion with the director of care and operations, it was not clear if there was an effective system in place to link people's needs to the levels of staff required. People's dependency levels had been assessed

using the Barthel Index of activities of daily living. (The Barthel index is a recognised method of assessing people's capability and dependency needs.) This produced a needs score, but this did not easily link to the numbers of staff in the home. For example, 13 people had a high-risk score from their Barthel assessment, but it was not clear from people's care files or the shift handover how staff were deployed to manage these risks. Also, it was not clear how staff were deployed effectively to limit the impact of periods of time when staff were busy delivering personal care, administering medicines or during lunch time.

We have recommended that the provider researches published guidance and practice in relation to the effective deployment of staff based on people's dependency levels.

The provider's recruitment policy was followed by recruiting managers. This protected people from new staff being employed who may not be suitable to work with people who needed safeguarding. Before employment, all applicants for posts at this home were asked to explain in full any gaps in their employment history. This was fully recorded and double checked by the manager. New staff could not be offered positions unless they had provided proof of identity, written references, and confirmation of previous training and qualifications. New staff had been through an interview and selection process. Applicants for jobs had completed applications and been interviewed for roles within the home. All new staff had been checked against the disclosure and barring home (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

Staff followed the provider's policy about safeguarding people. This was up to date with current practice. Staff were trained and had access to information so they understood how abuse could occur. Staff understood how they reported concerns in line with the providers safeguarding policy if they suspected or saw abuse taking place. Staff spoke confidently about their understanding of keeping people safe. Staff gave us examples of the tell-tale signs they would look out for that would cause them concern; for example bruising. Staff understood that they could blow-the-whistle to care managers or others outside of the home, about their concerns if they needed to. Staff were aware that people living with dementia may not always be able to recognise risk or communicate their needs.

The director of care and operations understood how to protect people from harm by discussing any concerns they had with care managers and the local authority safeguarding team. There were clear procedures in place to ensure allegations of actual or suspected abuse were fully reported to the local authority.

People had been assessed to see if they were at any risk from falls or not eating and drinking enough. If they were at risk, the steps staff needed to follow to keep people safe were well documented in people's care plan files. Additional risks assessments instructed staff how to promote people's safety. Actions had been taken to safeguard people. For example, people at risks were observed by staff to keep them safe. Also, staff understood the risks people living with dementia faced and made sure that they intervened when people became disorientated, or needed to be prompted to use a walking aid, like a frame.

Incidents and accidents records were checked by the manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. If people had falls, this was fully recoded so that patterns and frequency could be monitored with actions taken to minimise the risks. We saw investigations occurred that enabled learning from events and promoted improvements in practice. For example, in the prevention of infections in the home after an outbreak of diarrhoea and vomiting.

People were cared for in a safe environment and equipment was provided for those who could not weight

bear so that they could be moved safely. Equipment was tested and staff were trained how to use it. The premises were designed for people's needs, with signage that was easy to understand. The premises were maintained to protect people's safety. The maintenance records showed that faults were recorded, reported and repaired in a timely manner. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping.

People were protected from the risks associated with the management of medicines. People received their medicines safely from staff who had received specialist training in this area. The provider's policy on the administration of medicines followed published guidance and best practice and had been reviewed annually. Staff medicines competences were checked by management against the medicines policy to ensure good practices were maintained. We observed the safe administration of medicines. Medicines were stored safely and securely in temperature controlled rooms within lockable storage containers. Storage temperatures were kept within recommended ranges and these were recorded. Staff knew how to respond when a person did not wish to take their medicine. It would be offered again according to guidance from the GP. Staff understood how to keep people safe when administering medicines.

Medicines were correctly booked into the home by trained senior carers/head of care or the manager and this was done in line with the medicines procedure and policy. Trained staff administered medicines as prescribed by other health and social care professionals. For example, medicines specific to end of life care were well managed. 'As and when' required medicines (PRN) were administered in line with the PRN policies. This ensured the medicines were available to administer safely to people as prescribed and required.

The provider had policies about protecting people from the risk of home failure due to foreseeable emergencies so that their care could continue. The manager had an out of hours on call system, which enabled serious incidents affecting peoples care to be dealt with at any time. People who faced additional risks if they needed to evacuate had an emergency evacuation plan written to meet their needs. Staff received training in how to respond to emergencies and fire practice drills were in operation. Therefore, people could be evacuated safely.

Good

Is the service effective?

Our findings

Staff were trained to meet people's needs and people told us their health and welfare needs were met. We observed staff using equipment like hoist, to lift people safely and carrying out other task they had been trained to deliver. People said, "The staff are very good at their jobs and are very helpful."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called, the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. The manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Staff informed us that they had received appropriate training to carry out their roles. A training plan was in place. Training course availability were advertised for staff. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. Training was planned and specialised to enable staff to meet the needs of the people they supported and cared for. Staff received training in end of life care, and gained knowledge of other conditions people may have such as diabetes and dementia. New staff inductions followed nationally recognised standards in social care. For example, the new care certificate. The training and induction provided to staff ensured that they were able to deliver care and support to people appropriately.

Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. Staff told us that the training was well planned and provided them with the skills to do their jobs well. One member of staff said, "I have only been working here since August and I have had all the relevant training to enable to care for the residents. I love working here and we all work as a team." Another member of staff said, "I get on-going training." Training records confirmed staff had attended training courses or were booked onto training after these had been identified as part of staff training and development. This gave staff the opportunity to develop their skills and keep up to date with people's needs through regular training updates and meetings with managers. The director of care and operations told us that a senior carer was leading on the further development of dementia awareness for staff, by linking up with a specialist dementia nurses for training and advice.

Staff were provided with one to one supervision meetings as well as staff meetings and annual appraisal.

There had been 25 recorded supervisions since October 2016. Staff told us that in meetings or supervisions they could bring up any concerns they had. They said they found supervisions useful and that it helped them improve their performance.

People's health was protected by proper health assessments and the involvement of health and social care professionals. People had access to GP homes and other health care professionals such as occupational therapist and community nurses. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and the condition of their skin referred to as tissue viability. The care plans could be cross referenced with risk assessments on file that covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and reduce risk to people, including from the development of pressure ulcers.) Equipment was provided to minimise pressure ulcers developing; for example, air mattresses.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. However, relatives told us that the standard of food had been poor and on the first day of our inspection, only one choice had been offered at lunch time. Relatives told us that food was often cold by the time it arrived for people in the dining room as it was served in the kitchen and then transported to the dining room on a trolley. We spoke to staff and the director of care and operations about these issues. They told us that the chef had left at short notice the day before our inspection and the newly appointed cook had started without enough time to fully prepare for the lunch on the first day of our inspection. Kitchen staff confirmed that people were normally offered at least two choices at every meal and we observed that on day two of our inspection this was the case.

People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place. Care plans detailed people's food preferences. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

Good

Is the service caring?

Our findings

We observed staff who were friendly and genuinely caring towards people at Park View. Staff we spoke with had the right attitude to care and were committed to delivering compassionate care. People said, "The staff are lovely, kind and caring. My family are happy that I am here and being looked after well", and "I really like it here and wouldn't want to be anywhere else."

Relatives were made to feel welcome and could sit with people and chat in the lounge, conservatory or a quiet room. They were all pleased with staff and management communication and felt their family members were safe. A relative said, "Staff always keep us informed and up to date with any issues that may occur." Another said, "The girls (staff) on the ground are very nice. They are caring, I could not fault them in any way."

A health and social care professional had experienced staff who were welcoming and friendly. They said, "I find the staff very caring, they understand people's needs and know what people want."

We observed that staff were polite and cheerful. Staff took the time to understand how dementia or other conditions affected people. Staff got to know people as individuals, so that people felt comfortable with staff they knew well. Staff were aware of people's preferences when providing care. The records we reviewed contained detailed information about people's likes and dislikes and preferred names. We heard staff addressing people by their preferred names.

Staff spent time talking with people. The providers of the home had created a homely environment for people. People were able to personalise their rooms as they wished. They were able to bring personal items with them. We observed that staff knocked on people's doors before entering to give care. Staff described the steps they took to preserve people's privacy and dignity in the home. People were able to state whether they preferred to be cared for by all male or all female staff and this was recorded in their care plans and respected by staff.

Staff operated a key worker system. This enabled people to build relationships and trust with familiar staff. A key worker was a member of the staff team who worked with individual people, built up trust with the person and met with people to discuss their care. They took responsibility for ensuring that people for whom they were a key worker had up to date care plans and liaised with their families if necessary.

People had choices in relation to their care. Where appropriate, staff encouraged people to do things for themselves and stay independent. This was recorded in people's care plans and staff told us they followed this. People's privacy and dignity was respected. Staff closed curtains and bedroom doors before giving personal care to protect people's privacy. Staff we spoke with understood their responsibilities for preserving people's independence, privacy and dignity and could describe the steps they would take to do this.

The atmosphere in the home was relaxed. There were quiet areas people could go to if they wished to sit

away from others. For example, at lunch time people either chose to eat in the dining room, lounge or in their bedrooms. We observed that staff spoke to people with regularity and people were not left in isolation. We observed staff speaking with people in a soft tone; they did not try to rush people.

The provider had a policy about record keeping and confidentiality. Staff followed the policy, records about people could only be accessed by authorised staff.

Good

Is the service responsive?

Our findings

People's care was kept under review and changes were made to improve their experiences of the home. Since assuming day-to-day control over the management of the home, the director of care and operations and the head of care were in the process of reviewing all of the care plans and mental capacity assessments for people. They were looking at making care plans more person centred around people's dementia needs, and at ways of improving staff accessibility to keep care plan records up to date.

People had opportunities to take part in activities. However, at the time of the inspection there was not a permanent and suitably qualified activities coordinator. A member of the care team had assumed the role of activities co-ordinator whilst suitable recruitment took place.

People's needs had been assessed and care plans had been developed. Information about individual people's likes and dislikes and their life stories, interests and preferences were being recorded. The director of care and operations told us that they had linked to a provider of training for dementia based on the 'NHS Core Skills and Training Framework.' This training would assist staff to improve the levels of person centred care and planning for people who used the home that were living with dementia. However, we noted that the current care plans lacked individualised focus in relation to people's needs around dementia. For example, there were no specific dementia care plans. This meant that people's experiences of the care may not always match their needs.

We have recommended that the provider researches and implements published guidance, for example from the Department of Health in England in relation to enabling good outcomes for people living with dementia, including appropriate activities.

Staff told us how they support one to one sessions with people who were cared for in bed or who chose to stay in their bedrooms. This helped to prevent people from becoming isolated. We saw pictures in people's care files of one-to-one sessions taking place and of entertainers who visited people. There had been events around Christmas for people to participate in and these had been recorded. Staff said, "We tend to concentrate on people in their rooms, we sit and talk, we learn a lot about people that way." And, "We try and encourage people down to the lounge where the main activities take place." During the inspection we observed the activities in the lounge. Staff were cheerful and upbeat with people and tried to encourage people to join in with singing and dancing or catching a soft ball. We observed people using quiet areas that were separate from the main lounge. One of these rooms had a reminiscence homely feel with vintage furniture, book shelves and books.

There were some people who received additional support from the community mental health teams. Clear support and advice about this was available to staff on record. People living with dementia had a reminiscence box outside their rooms to assist them to identify where they were. Others carried objects of reference they liked, for example life like soft pets that reminded them of their own pets. This demonstrated that the care people experienced was individualised to their needs. We saw records of referrals to GPs and other external professionals seeking advice from them when required. Staff kept records of when they

liaised with healthcare professions to make sure people received prompt care and treatment to meet their physical and mental health needs.

Changes in people's needs had been responded to appropriately and actioned to keep people safer. For example, we saw in a care plan that to minimise the risk of falls people had assistive technology in their bedrooms that alerted staff, especially at night, if people got out of bed. Care plans and risks assessments evidenced on going reviews. Referrals had been made when people had been assessed for specific equipment, which was in place. For example, some people had beds that provided protection from pressure areas developing and enabled staff to move the height of the bed up or down to assist the delivery of care.

For some people their needs required staff to maintain records to maintain people's health and wellbeing. For example, dependency assessments with an emphasis on weight and body mass indicators. Staff had implemented weight management plans based on advice from a dietician and emergency health care plans in response to people's illnesses. We cross checked this against the care plans and found they were kept under review. This had resulted in the people maintaining their health through good hydration and nutrition and minimised the risk of infection. However, we found that in one person's care plan that they had been admitted to hospital and were dehydrated. There were no records that staff had been monitoring the persons fluid intake prior to the hospital admission. We spoke to the director of care and operations about this and they told us that prior to the hospital admission the person had not been assessed as requiring additional monitoring. They told us that they were reviewing the effectiveness of the assessments for this within their care plan reviews. Since returning from hospital the persons fluid intake was being recorded. Monitoring people's fluid intake helped reduce the risk of infection and dehydration to protect people's wellbeing.

Relatives spoken with said they were happy to raise any concerns. They told us that the management and staff were all very approachable. Four relatives told us about particular concerns they had about their loved ones clothing going missing. We discussed this with the director of care and operations who told us they were working to resolve these issues by working with families to properly identify clothing and belongings. They showed us evidence that they were investigating the underlying causes of the disappearance of clothing. One of the relatives concerned told us that the provider was taking responsibility for these issues by offering to reimburse people if clothing could not be located. Four formal complaints had been received about the home in 2016. We could see that complaints had been dealt with to people's satisfaction. The director of care and operations had followed the provider's complaints policy and investigated complaints, recoded responses in writing and kept a log of complaints for audit purposes. People and their relatives could attend meetings in the home where they could talk about any concerns or complaints they had about the care. The management always tried to improve people's experiences of the care by asking for and responding to feedback.

Good

Is the service well-led?

Our findings

The provider was in the process of recruiting a manager who could apply to register with the CQC. Several managers had been appointed to the post since February 2016, but they had not been suitable to continue in role. The provider's director of care and operations had been in charge of the home since 29 November 2016. They were being supported by a management team led by a head of care.

Staff were open and honest with us when we spoke to them. They told us that previous managers had not organised the staffing properly, and that they had caused lots of good staff to leave. However, staff also told us that with the director of care and operations now in charge of the home things had got a lot better. Staff said, "I would not still be here if things had not been improving." And, "Everything is being resolved by the director of care and operations."

People benefited from a provider that monitored the quality and people's experiences of the home. The director of care and operations and the head of care had carried out a review of the care plans, staffing levels, how staff were supported, the recruitment of staff and the experiences of people and their relatives. They had developed and were working on an improvement plan so that they were correcting some of the issues left by the previous manager. For example, staff supervisions were now taking place. This meant that the provider had identified, recognised and responded to deficiencies in the home, raised through their internal quality monitoring systems.

People were protected by checks that risk assessments, care plans and other systems in the home were working and up to date. All of the areas of risk in the home were covered; fire test, fire evacuations and servicing of systems were up to date. Each audit had an action plan. The director of care and operations, head of care and senior care workers carried out regular audits of health and safety risks within the home and of the quality of the home provided. The director of care and operations told us that the provider listened to, considered and acted on requests made for additional resources. For example, since our last inspection the dining room had been moved to improve people's experiences and facilitate the better use of the communal areas in the home. A stair lift had been fitted as a back-up when the lift was being repaired and the laundry had been made bigger to enable the separation of clean and dirty areas. This demonstrated continued investment and improvement in the home to improve the quality of the home provided.

General risk assessments affecting everybody in the home were recorded and monitored by the management. Up to date general risk assessments were displayed in key areas of the home. For example, near the stair lift. These assessments informed visitors and staff of potential risk and what control measures were in place. This increased the awareness of how to reduce risk within the home. Audits of the quality of care in the home were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits covered every aspect of the home.

Management reviewed the quality and performance of the home's staff. We could see that the current management in the home used the provider's policies to both promote good practice and offer staff career

development opportunities and measure staff performance. This included formal meetings and correspondence asking staff who were not performing well to improve. Staff told us that staffing levels and team working had improved under the management of the director of care and operations and head of care. Staff said, "Things were not working well under the old manager, lots of staff left and moral was low. Now with the new managers things are stabilising, they are much more approachable and get things sorted out if we raise issues." Another member of staff said, "We had been short staffed but this is now improved."

Staff told us they were now being supported in their roles. There were various meetings arranged for staff. These included daily shift hand over meetings. These meeting were recorded and shared. We observed a hand over meeting which gave staff coming on shift a clear picture of events and activities that had taken place on the previous shifts. Staff said, "Hand overs happen every day and they are useful." Information about how staff could blow the whistle was understood by staff. Staff told us about their responsibilities to share concerns with outside agencies when necessary. Staff also confirmed that they attended team meetings. Staff felt that they could speak up at meetings and that the management listened to them. Staff said, "We go through all the issues/concerns we may need to report to managers in our training, the management constantly remind us that people who use the home come first."

There were a range of policies and procedures governing how the home needed to be run. They were kept up to date with new developments in social care. The policies protected staff who wanted to raise concerns about practice within the home.

Maintenance staff ensured that repairs were carried out quickly and safely and these were signed off as completed. Other environmental matters were monitored to protect people's health and wellbeing. These included legionella risk assessments and water temperatures checks, ensuring that people were protected from water borne illnesses. The maintenance team kept records of checks they made to ensure the safety of people's bedframes, other equipment and that people's mattresses were suitable. This ensured that people were protected from environmental risks and faulty equipment. The manager produced development plans showing what improvements they intended to make over the coming year. These plans included improvements to the premises.

The management was proactive in keeping people safe. They discussed safeguarding issues with the local authority safeguarding team. The manager understood their responsibilities around meeting their legal obligations. For example, by sending notifications to CQC about events within the home. This ensured that people could raise issues about their safety and the right actions would be taken.