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

Summary of findings

Overall summary

This inspection took place on 6 June 2016 and was unannounced.

At the last inspection on 30 November and 7 December 2015 we rated the service Inadequate and in 'Special Measures'. Although we found some improvements had been made following our inspection in April 2015 we still found seven breaches in regulations which related to medicines, staff recruitment, staff training, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), person-centred care, complaints and good governance.

Placements at the home were suspended following our inspection in April 2015 when we identified multiple breaches and first rated the service as Inadequate and in 'Special Measures'. The commissioners at the Local Authority and Clinical Commissioning Group (CCG) have continued to work with the provider to support them in making improvements to the service.

We carried out this inspection to check if the improvements stated by the provider in their action plan had been made. The suspension on placements was still in place when we visited.

Park View Nursing Home provides accommodation and nursing care for up to 43 older people. There were 17 people living at the home when we visited.

Accommodation is provided over three floors with lift access between the floors. There are communal lounges and a dining room as well as toilets and bathroom facilities. A kitchen is located on the ground floor and laundry in the basement.

The home had a registered manager who left in May 2015. A new manager was appointed and was still in post at this inspection. 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.

Overall we found significant improvements had been made in the home since our last inspection

People told us they felt safe and we found there were enough staff on duty to meet people's needs. However, we remain concerned at the impact the lack of employed permanent nurses will have on the long term sustainability of safe care and treatment, particularly when admissions to the home re-commence.

Staff understood safeguarding procedures and how to report any concerns. Safeguarding incidents had been identified and referred to the local safeguarding team and reported to the Commission. Risks to people were assessed and managed to ensure people's safety and well-being.

The home was clean and well maintained and effective systems were in place to ensure these standards were maintained.

Robust recruitment procedures were in place which helped ensure staff were suitable to work in the care service. Staff received the training and support they required to carry out their roles and meet people's needs.

Medicines management systems had improved and were being monitored through regular audits. This helped to ensure people received their medicines when they needed them.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

People told us they enjoyed the food. Lunchtime was a pleasant experience with people offered choices and given the support they required from staff. People's weights were monitored to ensure they received enough to eat and drink.

People and relatives praised the staff who they described as 'good' and 'kind'. We saw staff treated people with respect and ensured their privacy and dignity was maintained.

Leadership and management of the home had improved and staff praised the manager who they credited with making the improvements in the home. Staff said teamwork had improved which they felt had benefitted the people who used the service.

Effective quality assurance systems were in place although these were in their infancy and needed to be fully embedded to ensure continuous service improvement. We need to be assured that the provider will continue to provide the manager with the necessary support to ensure the improvements made will be sustained and developed further to make sure people consistently receive high quality care.

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.

Medicines management had improved and people were receiving their medicines as prescribed.

There were enough staff to support people and keep them safe, although the lack of permanent nurses employed by the service remained a concern. Staff recruitment processes ensured staff were suitable to work in the care service.

Risks to people's health, safety and welfare were assessed and mitigated as detailed in people's care records. Staff understood safeguarding procedures and incidents were reported appropriately

The premises were clean, secure and well maintained, although further action was needed in relation to window restrictors, locks on bedroom doors and call bell facilities in ensuites.

Is the service effective?

Good

The service was effective.

Staff received the training and support they required to fulfil their roles and meet people's needs

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

People were provided with the support they required to ensure their nutritional needs were met.

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 'good' and 'kind'.

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

People's views were listened to and acted upon

Is the service responsive?

Good

The service was responsive.

Care records showed the support people needed and their preferences.

People were provided with group and individual activities in-house as well as regular 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.

Improvements had been made to address the issues identified at the previous inspection and the leadership and management of the home had improved.

However, quality assurance systems were not fully embedded and we would need to see evidence of sustainability and continued improvements before we could conclude the service was well-led.

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 6 June 2016 and was unannounced. The inspection team consisted of three inspectors.

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.

Before the inspection, the provider completed 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. We reviewed this information before the inspection.

We spoke with nine people who were living in the home, one relative, three care staff, one nurse, the catering manager, the maintenance manager, the housekeeper, the activity co-ordinator, 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

We found improvements had been made in all areas covered in this domain and there were no regulatory breaches. However, the rating remains Requires Improvement as we need to be assured these improvements are consistently sustained over time.

Following the last inspection in November 2015, the manager had made changes to the medicine systems. Previously medicines had been supplied in a monitored dosage system and were stored in a medicine trolley. At this inspection we found each prescribed medicine was packaged separately and locked medicine cupboards were provided for each individual in their bedroom. The manager had also implemented a system whereby the nurse administering the medicines had to count and record the stock balance for each medicine after administration. The manager told us this had reduced the number of errors and had ensured any discrepancies were quickly identified.

People we spoke with told us they received their medicines when they needed them. One person said, "They make sure I get my tablets at the right times." Each person had a medicine administration record (MAR) file which contained a photograph of the person, noted any allergies and recorded how they liked to take their medicines. For example, it was recorded one person liked to take all their tablets together and we saw this was the case. Although we noted the nurse did not take this for granted and asked the person how they wanted to take them and we heard the person reply, "All together."

We observed the nurse during the morning medicine round. The nurse told us no one received their medicines covertly. The nurse was calm and efficient and followed good practices to ensure medicines were administered safely. For example, they wore gloves when handling medicines and changed these between each person. They checked the medicine label against the MAR, signed only when the medicine had been taken and counted and recorded the remaining stock. We saw the nurse was patient and kind with each person giving them support where needed and staying with them until the medicines had been taken. We saw people we asked if they required any pain relief.

There was detailed information to guide staff as to when and how often to administer 'as required' medicines. We saw times were recorded when 'as required' medicines had been offered and given as well as the number of tablets where the dose was variable. Administration records for the application of creams and ointments were well completed. Our discussions with the nurse and review of records showed effective systems were in place for the ordering and disposal of medicines.

The clinical room was clean and well ordered. Records showed temperatures of the clinical room and medicine fridge were up to date, monitored daily and within safe ranges. Bedroom temperatures were recorded daily. However, records showed in one bedroom the temperature had exceeded the maximum recommended 25°C on several occasions in the three weeks leading up to the inspection. Medicines may spoil or become unfit for use if they are not kept at the correct temperature. We discussed this with the manager who said they would address this straight away.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CD). We found these medicines were kept securely and records were completed correctly. We checked the stock balance of two people's CDs and they were correct.

People told us they felt safe at the home. One person said, "It's alright, very stable and very safe." A second person told us, "I feel safe living here." A third person said, "I feel safe living here, it's nice, no nastiness."

Staff told us they had received training in safeguarding adults and were clear about how to recognise and report any suspicions of abuse. They were aware of the whistleblowing policy and knew the processes for taking serious concerns to external agencies if they felt they were not being dealt with effectively. Safeguarding records showed the manager had made appropriate referrals to the local authority where concerns had been identified. This showed us staff were aware of the systems in place to protect people and how to raise any concerns.

There were sufficient staff to meet the needs of people currently living in the home and to ensure they received safe care. One person told us, "If I press my buzzer staff come straight away."

The provider used a tool to calculate staffing levels based on people's dependency. This determined one nurse and four or five care workers were required during the day and one nurse and two care workers at night. The rotas we looked at confirmed these staffing levels were maintained. Our observations of care and support found staff were visible and able to provide assistance where required.

However, we were concerned about the lack of permanent nursing staff. The only nurses employed by the service were the registered manager and deputy manager, but these staff usually worked in a supernumerary capacity. All other nurses were provided by an agency. For example, for a two week period in May 2016 out of 28 shifts in a week, we identified only four shifts were provided by the deputy manager with the rest covered by agency nurses. This risk was somewhat mitigated as the provider sought assurance from the agency that the nurses provided had the correct skills and knowledge. Steps were also taken to ensure the same nurses were provided to improve consistency of care and allow staff to develop knowledge of people and their needs. For example, some agency nurses had been working at the service for a year. However, we remain concerned about the impact the lack of permanent employed nursing staff will have on the long term sustainability of safe care and treatment, particularly when admissions to the home re-commence.

Safe recruitment procedures were in place. These included ensuring prospective staff completed an application form and detailed their employment history and qualifications. Checks on staff character were completed to ensure they were suitable for the role. This included obtaining a Disclosure and Barring Service (DBS) check, obtaining references and ensuring an interview was held. The registration of nursing staff was checked and monitored to ensure it did not elapse.
Where agency staff were utilised assurances were sought from the employment agency that the required checks on their skills, knowledge and character had been completed. Agency staff were also subject to competency checks and/or supervision where required.

Risk assessments were in place which covered areas such as nutrition, skin care, moving and handling and bed rails. We saw where risks had been identified action had been taken to mitigate the risk. For example, people who had been assessed as being at risk of falling had 'falls mats' in place. These mats trigger an alarm if the person starts to get out of the chair or bed so staff can offer assistance. This meant staff were identifying risks to individuals and taking action to reduce those risks.

We saw skin integrity care plans showed how often people were offered pressure relief and what equipment they had in place to reduce the risk. Manual handling risk assessments contained clear information on how many staff were required and the nature of any lifting. Where people developed sores or wounds these were documented within the care records. We saw evidence these wounds were subject to regular review and treatment by nursing staff and other health professionals were involved where appropriate.

We saw fire notices were on display informing visitors and staff about what they needed to do if the fire alarms went off. Staff were able to tell us the action they would take if the fire alarms sounded and we saw people had Personal Emergency Evacuation Plans (PEEPs) which were up to date. This meant in an emergency staff knew what to do to keep people safe.

We asked people using the service if they were happy with their accommodation. One person told us, "I like my bedroom and it is kept clean and tidy. A second person told us, "My bedroom is kept clean and tidy and it is comfortable." One relative told us, "It's always clean and tidy and there are never any unpleasant odours."

We looked around the building and it was clean, tidy and odour free. We spoke with the housekeeper who told us new detailed cleaning schedules had been introduced, which ensured standards of cleanliness were maintained. They also said the new cleaning products they had were much more effective than the ones they had previously used.

Staff told us they had received infection prevention training. We saw there were stocks of disposable gloves and aprons available on corridors. These together with disposal bags and wash mitts were also available in people's bedrooms where they needed to be used by staff.

We saw the food standards agency had inspected the kitchen in May 2016 and had awarded them 5* for hygiene. This is the highest award that can be made. This meant food was being prepared and stored safely.

The provider told us about some of the improvements they had made to the premises since our last inspection in December 2015. These included some structural changes to remove a fire exit from a bedroom, improvements to the storage facilities in the laundry and moving the staff room to a better location.

We saw people's bedrooms and lounge areas were nicely decorated and comfortably furnished. We saw some ensuite toilets did not have emergency call bells in them. However, some of these toilets were not being used by the occupant as they had commodes in their bedroom. We also saw some people wearing pendant call bells around their neck which they used when they needed assistance from staff. We noted none of the bedroom doors could be locked and some top opening windows had the type of restrictor on them which could easily be disabled. We brought these issues to the provider's attention so they could consider making improvements to these areas.

The maintenance manager told us staff were very good at reporting any repairs which were needed. For example, on the day of our visit staff had stuck a broken eye from a hook and eye fixing in the repairs book to show exactly what repair was required. This meant there was a good system in place to make sure repairs were completed in a timely way.

A maintenance worker was employed who was responsible for ensuring checks on the building took place to help ensure it was safe. Records showed the maintenance manager undertook a daily walk round of the building as well as weekly bedroom checks and appropriate checks on the fire, water, gas and electric systems taking place. Equipment such as hoists and wheelchairs was also subject to regular checks to

ensure they were kept in safe working order.

Good

Is the service effective?

Our findings

Staff we spoke with told us there was 'loads of training' on offer and showed us the training matrix in the staff room. One staff member said, "The e-learning has gone down well as it can be done at work or at home."

All permanent staff were in the process of completing the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

In addition, staff received regular training updates in subjects such as manual handling, the Mental Capacity Act (MCA), medicines and moving and handling. This was a mixture of face to face training and e-learning. Training was monitored by the manager so if any training was overdue an update could be promptly addressed with staff. On reviewing training records we saw the vast majority of training was up-to-date. Agency staff also had access to this training if required and had their competency assessed where there were concerns. For example, around medicines management. The agency nurse we spoke with confirmed they had received medicine training through the agency but were also in the process of completing the home's medicine training. Specialist training was provided to some staff. For example, pressure area training from tissue viability nurses.

One staff member said, "It's a good staff team, I enjoy working with them. We all pull together from the nurses to the laundry staff." Another told us, "Staff are flexible and will swap shifts with you if needs be."

Staff told us they received regular supervision and an annual appraisal. This looked at areas such as safeguarding, effectiveness in the role, goals and objectives. This was planned in advanced by the registered manager to ensure people received this support on a regular and consistent basis. One staff member showed us the duty rota which clearly identified planned supervision sessions.

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.

The manager told us there were five people who had DoLS authorisations in place and an application had been made for two other people. All five DoLS authorisations had conditions in place. We saw these had been fully documented within people's care records and care plans put in place detailing how the service would meet the conditions surrounding their DoLS.

Staff 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.

We saw summary sheets which showed people's care had been discussed with them and that they had consented to the care and treatment provided, including medicines. They had also signed consent in relation to photographs and sharing information. We observed staff explained to people what they were proposing to do and checked they were in agreement before providing any support.

People told us meals at the home were good. One person said, "The food is good and we always get a choice." A second person said, "The food is pretty fair." One relative told us, "The meals are very, very good."

Staff told us they had received training about diet and nutrition. Nutritional risk assessments identified people who were nutritionally 'at risk' and care plans showed what action staff needed to take in order to mitigate the risks. For example, making sure people received any prescribed food supplements and how often they needed to be weighed.

A chart displayed in the staff room gave information about people's weights and showed if people had maintained, lost or gained weight over a period of months. Information about people's diet and fluid intake was also displayed on a central board, which we saw staff referred to and updated throughout the day. Staff used the board to confirm people had been given their meals and to highlight if people had not eaten very much. Staff told us, for example if someone had not eaten much breakfast they would make sure they had a mid-morning snack and/or more to eat at lunchtime.

Systems were in place to ensure people were sufficiently hydrated. Each person had a target fluid input based on NICE guidelines target amount of 30mls/kg. Care records provided evidence that generally these target fluid inputs were met on a daily basis. The central board also reflected people's fluid intake so staff could easily see who needed to be encouraged to drink more. We saw people looked well hydrated and plenty of hot and cold drinks were offered to people throughout the day. However, we also identified where people's weight had changed the target fluid input had not always been adjusted. We raised this with the manager who agreed to ensure this was reviewed.

Staff said they always offered people meals first and then if people had been prescribed food supplements these were given between meals or if the person had not eaten very much. The records we reviewed confirmed people received their supplements as prescribed. We concluded this monitoring ensured people were receiving adequate nutrition and hydration.

The day's menu was displayed in the dining room in pictorial form, showing the choices available for each meal. Mid-morning people were asked by the activities co-ordinator for their choice of lunchtime meal of either cottage pie or gammon.

At lunchtime we saw the tables had been set with tablecloths, napkins and cutlery. People were offered hot and cold drinks and their choice of meal was served. People were offered extra gravy and extra butter for their mashed potatoes. One person had ordered cottage pie but when the meal arrived they decided they would like gammon instead. We saw this did not cause any problems and they were given the meal they wanted.

Where people needed assistance from staff we saw this was provided in a caring and compassionate manner. For example, one person did not want their main meal but when offered rice pudding readily

agreed to the dessert. The care worker who was assisting them explained to us this person had eaten two breakfasts.

The catering manager had a good knowledge of people's dietary preferences and told us how they fortified foods for people who were at risk of losing weight. They used their knowledge of people's particular likes to tempt them if they were not eating. For example, they said one person would often eat an omelette if they did not want anything else.

People's healthcare needs were met by the service. Health related care plans were in place which covered any medical conditions and stated the required healthcare to be provided by the service. Health monitoring of people was undertaken. For example, checks were made on their pulse, blood pressure and oxygen saturation to help ensure any deterioration in their condition was promptly identified.

Information on people's medical conditions was present within their care plans and whether they were subject to a Do Not Attempt Resuscitate (DNAR) order. At the time of the inspection, local health professionals were providing enhanced support to the provider as part of a programme of improvement. For example, two people who were funded for nursing care had wounds that were being cared for by the local district nursing team. Care records demonstrated the service liaised with health professionals such as GPs, district nurses and community matrons.

Good

Is the service caring?

Our findings

One person using the service told us, "The staff are kind." A second person said, "You couldn't wish for better staff, they are all very kind." A third person told us, "Staff are hardworking and very good." A fourth person said, "The staff are fine, they look after me very well." A fifth person commented, "The staff are fantastic, lovely and you can have a laugh with them." A sixth person said, "Staff are very nice, friendly and helpful."

One relative told us, "The staff are very good, without exception." A second relative said, "Staff are caring and everyone is pleasant."

A member of staff told us, "Life has improved for people living here and I have seen an improvement in people's appearance."

The manager told us they were a Dignity Champion. We saw information about dignity in care was on display in the dining room, to remind everyone about the 'Dignity Do's'. For example, these included treating people with respect, enabling people to maintain their independence and to be able to complain without fear of retribution. We observed staff treated people with respect and ensured their dignity was maintained. Interactions we viewed between staff and people were positive with staff taking the time to listen to people's views on how they liked their care and support to be delivered.

We saw people looked well cared for. People were wearing clean clothing, men had been shaved, people's spectacles were clean and their hair had been brushed or combed. We found information in people's care files about their past lives and experiences, likes, dislikes and preferences. This helped staff to understand the people they were caring for in order to provide more personalised care and support. We saw staff knew people well and understood how people liked to be cared for. For example, staff told us if one person would not eat anything else, they would always eat chocolate. This showed us staff used the information they had about people to provide them with a personalised service.

We found a pleasant atmosphere within the home with staff and people getting on well. The home was notably quieter than during previous inspection visits and had a more homely feel. It was a hot, sunny day when we inspected and a lot of the people were assisted by staff to sit outside. Some people chose to sit in the shade, whilst others wanted to enjoy the sunshine. We saw staff were attentive and made sure people who wanted sun hats had them and that sun cream was also offered. Staff also asked people if they wanted to change their clothing if they were too warm.

Last time we inspected the service we spoke with one person who was in bed and quite low in mood. On this visit we saw they were up, spent time sitting outside and were laughing and joking with staff.

The two relatives we spoke with both told us they were made to feel welcome when they visited and were offered a drink.

We saw useful information for people and relatives was freely available in the home. This included the last

inspection report, leaflets about advocacy, Alzheimers and the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Good

Is the service responsive?

Our findings

We found improvements had been made to recording the planning and delivery of care. Care records showed people's care needs were assessed in a range of areas including mobility, skin, continence, personal care and social activities. Detailed and person centred care plans were in place which provided staff with clear information on how to provide the care. For example, one person's wound care plan reflected the treatment regime advised by the tissue viability nurse and evaluations showed this had been followed by staff. On reviewing daily records we saw evidence that people's care needs were being met.

Overall, care records demonstrated staff undertook the required checks on people to ensure they were kept safe. For example, a number of people were checked two hourly to ensure their health and welfare. However on occasion, particularly in the early morning there was a lack of evidence of checks. We established this was likely due to the time delay in some staff in entering information into the system following health and care checks.

Care plans were subject to regular review. The manager kept a board which detailed when each person's care plans and risk assessments required updating. This helped ensure updates were made in a timely way.

Assistive technology was utilised by the service to allow it to quickly respond to people's needs. For example, where assessment indicated necessary, continence and pressure mats were in place within people's rooms which were linked to the call bell system. We checked a sample of these rooms and saw this equipment was in place in line with the agreed care plan.

People using the service told us there were a variety of activities on offer to keep them occupied. One person said, "Singers come in and we do exercises and quizzes." A second person told us, "Sometimes they take me out to the park."

One relative told us, "The entertainment is really, really good and they get them [the entertainers] in pretty frequently."

We spoke to the activities co-ordinator who told us they worked at the home from 10:00am to 5:00pm five days a week. They explained they usually worked Monday to Friday but would work at the weekend for special occasions. We saw they had a weekly programme which included both group and individual activities. For example, puzzle books, board games, dominoes, art, bingo and afternoon films. In addition to this we saw on the notice board three different entertainers had been booked for June as well as a Communion service.

The activities co-ordinator had a list of people's likes and dislikes, which helped them to offer people appropriate activities. We saw them spending time with individuals playing dominoes and offering support with a crossword. We heard them rephrasing the clues to the puzzle to help the person to find the answers.

The activities co-ordinator had also produced the home's first newsletter for April/May. This provided people

with information about up and coming events, photographs of the Queens 90th birthday celebrations at the home and a puzzle page.

We also saw people using the service, staff, friends and relatives had raised £87 for charity on 'Wig Wednesday' and had provided afternoon tea for those participating.

People using the service told us if they had any concerns they would tell a member of staff, the nurse on duty or the manager. We saw the complaint policy was displayed in the home and complaint/suggestion forms were freely available in the entrance hall. A suggestion box was provided so people could submit the forms at any time. We saw five complaints had been received since the last inspection. The records showed each complaint had been investigated, recorded any actions taken and the response made to the complainant.

Requires Improvement

Is the service well-led?

Our findings

As demonstrated in other sections of this report, we found the manager and provider had worked hard to secure improvements for people in all aspects of service delivery. This was evident from our observations and feedback from people, relatives and staff. However, we found the quality assurance systems were in their infancy and were not yet fully embedded to ensure continuous improvement of the service. Before we can conclude the service is well-led we need to be assured that the provider will continue to provide support to the management of the home and fully implement effective quality assurance systems to ensure any improvements will be sustained and developed further to make sure people consistently receive high quality care.

Staff we spoke with said the service was well-led and were keen to tell us about the improvements which had been made. They told us the manager led by example and had driven the improvements since our last inspection. One staff member said, "[Name of manager] has driven the changes and her dedication is unreal, she is an excellent manager. She wants to make this a fantastic home for residents to live in and her passion rubs off on staff. I love working here [name of provider] is a good boss to work for. You can go to either of them and know they will keep things confidential."

Another staff member told us, "[Name of manager] has driven the changes and has said this is what we have to do." Staff also told us they would recommend the home and would be happy for a relative to be looked after at Park View Nursing Home.

We found there was an open and honest culture in the home. Staff told us they worked well as a team and how much they enjoyed their jobs. Staff explained to us there was more accountability now and checks were being made to make sure care was being delivered to the correct standards. One staff member said, "Staff take a pride in what they do." Another told us, "All of the staff want to be here and I am happy to work with any of the team. It's been a team effort to get where we are. [This comment was in relation to the improvements which had been made.]" A further staff member said, "It's a good staff team, there is a good atmosphere and team work has brought about the changes."

The home does not have a registered manager. The manager's intention is to register with the Care Quality Commission, however, we are unable to accept an application to register a manager at this time. 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. The rating was not shown on the provider's website, although the manager acknowledged this was an oversight and it was addressed following the inspection.

Following the last inspection the manager had implemented systems to assess and monitor the quality of the service. Regular audits in areas such as medicines, infection control, hand hygiene, mattresses and equipment and care plans were undertaken by the manager. We looked at these and saw they were effective

in identifying issues and making sure action had been taken to rectify any problems.

Our discussions with the manager showed they understood the importance of these systems and were using them to make sure improvements were maintained, developed and sustained. For example, we saw detailed monthly medicine audits which contained action plans to address any issues and were risk rated to determine the timing of any follow up. We saw a recent audit had identified some minor discrepancies in practice and as a result the medicine audits had been increased to weekly to ensure these were fully addressed.

The manager showed us care plan audits which reviewed care records of three people each month. Although these had only been completed for a small number of people the audits we saw were detailed and resulted in action plans for the named nurse to address any issues identified. We saw these actions were followed up to ensure they had been completed.

We saw monthly infection control audits which demonstrated the improvements made since November 2015 when the overall compliance score was 79% to May 2016 when the score was 93%.

We spoke with the maintenance manager who told us they completed the mattress audits. Following the first audit four mattresses had been condemned and taken out of use. They told us these audits would now be completed every six months.

One member of staff told us, "All of the checks we are making on the building have made it a lot safer for the residents."

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. For example, two incidents identified had happened when staff were transferring people. The manager spoke with all staff about this and arranged for practical moving and handling training to be delivered.

We saw residents, relatives and visitors meetings had been held in February and April 2016. A lot of discussion had taken place about our last inspection report and people had been given the opportunity to ask questions. At the last meeting the results of the surveys and suggestions had been discussed.

People's views were also sought through periodic questionnaires. For example, people's feedback had recently been sought on the quality of the food and dining experience. The findings of this survey were then discussed at the residents' meetings to seek further clarity on comments and to allow changes to be made to the menu. We saw suggestions made by relatives were listened to and acted on. For example, one relative had asked for a settee to be provided in the lounge so they could sit closer to their family member and we saw this had been provided.

Staff meetings were held periodically, which included management meetings and care worker meetings. We looked at the minutes from these meetings which showed a range of quality issues were discussed including the provider's improvement plan in order to help improve the quality of the service.