YMICARE Limited

Parklands Residential Home

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection visits took place on 3 and 5 March 2015 and were unannounced. The inspection team consisted of one inspector.

At the last inspection on 08 May 2014, we asked the provider to take action to make improvements toward the safe management of medicines and record keeping. We found those improvements had been made.

Parklands Residential Home provides personal care for a maximum of 27 older people with dementia and other mental health conditions. People's health care needs are met through community health care services. There were 24 people using the service at the time of the inspection.

Parklands Residential Home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

The arrangements for the running of the home and monitoring of the service people received had not been effective. Effort had been made to get people's views and there had been no complaints but the registered manager and registered provider had not identified where improvement was needed and addressed it.

People were not always safe from people exhibiting distress and behaviours which were a challenge. Staff were not equipped to support the people with those behaviours; find out the cause and put strategies in place to help them.

The home smelt of urine despite the cleaning routines. Much had been done to upgrade the home but this had not yet included replacing malodorous carpets. The registered manager was aware of internal designs which promote the independence and well-being of people living with dementia but these had yet to be implemented. We have made a recommendation relating to the home environment.

People's privacy and dignity were not always met and the home looked institutional with many signs displayed which were to inform staff what to do, not enhance the environment; people's home.

Staff understood consent but helping people with decision making and ensuring they were as involved in their care planning as possible was not always put into practice.

People did not receive personalised care based on their history, interests and needs although there were regular activities provided at the home. Staff did their best to follow requests from people able to express their preferences and their interactions with people were caring and kind.

People enjoyed the food very much and their dietary needs were met. People were regularly encouraged to have food and drinks.

Recruitment practices helped to protect people from staff who might not be suitable to work in a care home. Staff had the opportunity to make their views known and they felt supported through team work and the availability of the registered manager.

People received their medicines in a safe way and as prescribed. Health care professionals were contacted immediately any concern was identified and a district nurse said end of life care at the home was provided by a "sensitive and empathetic team".

We found breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were at risk from the behaviour of other people at the home who may become distressed or angry.

The home smelled of urine and the laundry service did not fully protect people from the risk of infection.

Staffing arrangements ensured people's needs and preferences could be met.

People's medicines were given as prescribed and in a safe way.

Recruitment practices protected people from staff who might not be suitable to work in the home.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff lacked some necessary skills to care for people effectively, such as how to support people with behaviours which were a challenge and safe moving and handling.

Insufficient effort was made to ensure people were consenting to the care they received and the principles underlying the Mental Capacity Act 2005 were not part of routine care.

Good practice, with regard to the environment, had not yet been implemented to promote peoples' well-being.

People's dietary needs were well met and people liked the food very much.

People were happy with the care they received and a district nurse said they were quickly contacted where necessary.

Is the service caring?

Requires Improvement

The service was not always caring.

People called out when they needed the toilet, a bedroom was offered for use without the person's consent and people's laundry was sometimes lost and often creased and untidily stored. These practices compromised people's privacy and dignity.

The home had many signs displayed telling staff what they needed to do. This gave an institutional feel to the home.

It was not clear people were supported to express their views.

Summary of findings

Staff cared about people and relationships with them were kind and thoughtful. A district nurse said end of life care at the home was provided by a "sensitive and empathetic team".

Is the service responsive?

Requires Improvement

The service was not always responsive.

People living with the condition of dementia did not receive personalised care because staff had not been trained to provide this. Activities were not always based on the person's history, preferences or interests.

Care plans were regularly reviewed and people's health was monitored.

There were no recent complaints to the service but the registered manager was available to receive information and feedback.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not always protected through effective assessment and monitoring of the quality of the service provided.

The provider had not ensured an adequate standard of service for people.

Some staff did not feel valued, but teamwork was good and the registered manager was available for support.

The home was meeting its conditions of registration.

Parklands Residential 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 service, and to provide a rating for the service under the Care Act 2014.

The inspection visits took place on 3 and 5 March 2015 and were unannounced. The inspection team consisted of one inspector.

Not everyone was able to verbally share with us their experiences of life at the home. This was because of their dementia/ complex needs. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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. Before our inspection, we reviewed the information in the PIR along with information we held about the home, which included incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law. We received information from seven people professionally involved with Parklands Residential Home which informed the inspection.

During our visit we spoke to six people who used the service, three people's families, seven staff, the registered manager and the representatives of the provider organisation. We looked at records which related to five people's individual care and most people's medicine records. We looked at three staffing records, quality monitoring audits, equipment and utilities servicing records and some policies which related to the running of the home.

Requires Improvement

Is the service safe?

Our findings

People and staff were not always protected from harm. People said they generally felt safe at Parklands, with comments including, “Safe? Not a problem” and “Mum feels she is safe. Nice feel.” However, people mentioned their concerns about some people fighting and shouting at each other. We witnessed this in the lounge and there were no staff present to diffuse the situation. We had been notified of times when people using the service had behaved in a way which was a challenge and risk to others and the registered manager had informed the local authority safeguarding team about this, as she must to protect people.

Health care professionals were involved in management plans for those people exhibiting challenging behaviour. Those plans included the monitoring of triggers for the behaviours. However, those professionals were unable to express confidence in the staff’s understanding of such monitoring, the adequacy of care plans and staff understanding of how to support people with behaviours which challenged. One staff member, asked how they would respond to concerns about abuse, said they were fed up with being abused themselves. The night before our second visit a person had tried to bite staff. The registered manager contacted the person’s GP for advice.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff demonstrated an understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, staff knew to report concerns to the registered manager or the registered provider. They also knew where information about reporting concerns externally, such as the local authority, police and the Care Quality Commission (CQC), was displayed. However, the home’s policy on whistle blowing did not mention the word ‘abuse’ or include the contact details for the local authority safeguarding team and so the policy might not be as useful as it should. The registered manager said they would change this straight away for clarity. The PIR stated that 14 of the 23 staff at Parklands had received training in the safeguarding of adults and so the provider could not be assured that all staff had sufficient knowledge of how to protect people.

There was an unpleasant odour throughout the home, mostly in the entrance and lounge areas. One health care professional told us, “It smells of urine all the time”. A second also mentioned the unpleasant smell. Some of the lounge chairs were stained. The registered provider said the carpets in the main areas had been in situ for some years. They provided details of upgrading and maintenance of the home; this had not yet included the replacement of those carpets.

The laundry facility was not fit for purpose in that the walls, ceiling and floors were not readily washable due to peeling paint and plaster. The laundry was not very clean for this reason. However, the registered provider said that work was due to commence in the laundry on the Monday following our visits and was to include repairs to the exterior of the laundry building and improvements to the interior which would make the surfaces more readily cleanable. A member of staff confirmed that one of their tasks was a weekly clean of the laundry.

Laundry equipment was for professional use, and could reach suitable temperatures for soiled laundry, but the tumble dryer, although for professional use, was of domestic proportion. A care worker confirmed that the majority of people using the service were incontinent which would indicate a high volume of laundry and staff dried laundry in a communal area inside the home. This had the potential for this clean laundry to be contaminated from people who used the service handling it, which some did.

Protective clothing, liquid soap and paper towels were available to reduce the possibility of cross contamination and staff followed hand washing procedures. The PIR stated that 16 of the 23 staff had received training in the prevention and control of infection. Domestic staff were available seven days a week and the cleanliness of people’s rooms received a lot of attention.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People’s medicines were managed on their behalf because they were given the medicines they needed at the time they were required. One person told us they received their medicines when they were due and they were happy the staff managed their medicines for them.

Senior care workers ordered medicines from a local pharmacy and a monitored dosage system was in use

Requires Improvement

Is the service safe?

which reduced the possibility of mistakes. The PIR stated that seven of the 23 staff had received training in medication safe handling and awareness. Those staff were observed to administer medicines in a way which protected people from any mistakes.

Medicines were checked into the home, signed for when given and records kept of any medicines disposed of. Medicines were stored in a locked room, including those requiring refrigeration. Medicines known as controlled drugs were stored within another locked cupboard but this did not comply with the legislation specific for the storage of controlled drugs. Otherwise controlled drugs were managed in a safe way. The registered manager said the correct storage would be arranged immediately.

Medicine administration records (MAR) included a photograph of the person to receive the medicine, and any known allergies. This improved medicine safety. Other aspects of safe administration included two staff checking any hand written entry and the use of codes should a medicine not be given for any reason.

Risks to individuals were assessed. These included their room environment, moving safely and skin damage from pressure. A district nurse said the registered manager had contacted them without delay where two people were identified as at increased risk from pressure damage. Generic risks at the home were less well managed. For example, the fire safety risk assessment was missing at the time of the inspection but regular fire safety checks were completed.

There were recruitment and selection processes in place. Recruitment files of recently recruited staff included complete application forms and interview records. In addition, pre-employment checks were completed, which included references from previous employers. A care worker confirmed she had not started work before the checks were complete. Health screening and Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work with people using the service. A recently recruited staff member confirmed they had not started to work with people until their recruitment checks were completed.

Staffing arrangements ensured people's needs and preferences could be met. For example, people were supported to rise and retire at a time they preferred and there were enough staff to meet their daily needs, such as assistance with personal care and eating. One person said, "Just use your call bell and they pitch up quickly." Time was available for activities and completing monitoring records and staff appeared unrushed. The registered manager gave examples of where additional staff cover had been arranged and the support which was available for this, which included an on-call arrangement. The day of the visit there were six care workers, one domestic, one kitchen assistant and one cook on duty in addition to the registered manager.

Maintenance staff were available at all times to maintain the home in a safe state for people. Equipment and utilities were serviced and maintained to a safe standard. For example, flooring in the dining room had been repaired, all fire equipment had been replaced to comply with current fire regulations and bedrooms, bathrooms and toilets had been fitted with thermostatic valves to prevent the delivery of water which might scald people.

Measures were in place to manage emergency situations. A missing person's policy was displayed in addition to practical information about the home, such as where the stop cock was found should there be a water leak, and leaflets about emergency medical call outs. Staff said they were always able to contact the registered manager or registered provider if necessary.

Incidents and accidents were recorded and monitored by the registered manager who was able to describe why fluctuations had occurred. A district nurse confirmed that injury levels at the home were not outside of what she would expect for any comparable service.

Requires Improvement

Is the service effective?

Our findings

The majority of people using the service were living with the condition of dementia and their ability to make sense of their environment would be adversely affected by the interior design of Parklands. A senior community health practitioner described the interior of Parklands as "not ideal." For example, carpets had large patterns, lighting was poor in some areas and there was no use of colour to help people understand the different functions of rooms. This would adversely affect their independence and well-being. There were a few pictorial signs, such as to indicate the main lounge, in place to guide people. **We recommend that** the service explores the relevant guidance on how to make environments used by people with dementia more 'dementia friendly'.

Staff were encouraged to undertake qualifications in care and progress their careers. Staff said induction training was at least three days close supervision, longer if necessary, until they had confidence and enough knowledge to provide the care people needed. A staff member new to the home said they were very happy with the induction they had received. This meant that staff had started the process of understanding the necessary skills to perform their role appropriately and to meet the needs of the people living in the home.

Staff were not always equipped to meet the needs of the people in their care. The PIR stated that all staff had received certain training, such as fire safety and food hygiene, but many staff had not received training in other subjects. For example, no staff were recorded as having been trained in how to support people who had behaviours which were a challenge, although staff were dealing on a regular basis with people exhibiting those behaviours. The subject had been discussed in staff meetings. One care worker said they were to make sure any aggressive person did not block their access to the door. However, they did not mention identifying the cause of the person's distress or how to support them if they were distressed.

Health care professionals had raised concerns about some poor techniques in moving people safely; the registered manager had immediately arranged for further staff training. Only 14 of the 23 staff had received training in dementia care although most people using the service were living with the condition. Only three staff had received training in malnutrition care and assistance with eating although people using the service were at risk of malnutrition and assisting people to eat would be a regular role at the home. One staff said they were not trained to deal with any person at risk of choking but they were informed where this risk existed for any person, adding that they would provide the required drink thickener as necessary.

This is a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

A district nurse said that most staff were competent and they were very impressed with some staff that were "exceptionally good." Staff felt supported in their work through team work. Asked about staff support one said, "Very supportive. We all work as a team". Staff were working together and cooperating with each other. There were regular staff meetings and staff were able to "have their say". The meetings also provided staff information, such as anything senior care staff had noted needed to be fed back. The PIR stated that all staff received supervision of their work but no staff received an appraisal of their work. This was confirmed by the registered manager.

Staff demonstrated some understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Staff had an understanding that people should consent to care they received or decisions should be made in their best interest.

Where people might not have the capacity to make particular decisions about their care and support, due to their health condition, there was no evidence of promoting people's decision making, such as looking at ways to maximise their understanding. There were no records to show how people's capacity to make a decision had been assessed, such as whether the individual could understand the required decision. One example was the use of pressure pads which alert staff if the person moves around. People's families had been involved in the decisions but not the person themselves. However, 14 of the 23 staff had received training in the Mental Capacity Act and Deprivation of Liberty safeguards.

Requires Improvement

Is the service effective?

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The home had an understanding of how to protect people's liberty. The home had made applications to deprive people of their liberty following a Supreme Court judgement on 19 March 2014 which had widened and clarified the definition of deprivation of liberty. Those applications had not yet been assessed by the local authority and in the meantime the staff continued to make decisions in people's best interest. Two people told us they felt locked in the home but staff explained in detail how that was not the case. For example, each door, although locked for security, had a key in close proximity to open it and people were supported if they wished to leave the building. One example was taking a person shopping.

People said they were satisfied with the care they received although one said sometimes health concerns were raised by family, which had not been identified by the staff. However, they added, "They are quite good here." One family said their relative's health had improved since admission. One staff said, "The residents are looked after 100% and concerns are dealt with straight away. A district nurse said the staff were very good at contacting them appropriately although a social worker felt the contact was not always appropriate. They said when a person's behaviour changed this needed "greater thought" to identify if the change was due to something the staff could address.

One person was very keen to see their own GP and staff had made arrangements to achieve this. People were supported to receive the health care they needed, such as hospital visits and access to all appropriate health care professionals. For example, a physiotherapist assessed and arranged equipment for one person during our visit. However, they reported having seen a person struggling to get up from a chair which was too low for them. We also saw a person, who was supposed to be able to get themselves out of a chair, needing help to stand.

People received a nutritious and varied diet which they enjoyed. People told us how much they enjoyed the food they received. Their comments included, "The food is excellent"; "The food is good" and "I'm fussy but its good food." There was a choice of three lunch time meals the first day of our inspection; toad in the hole, corned beef hash or scampi.

People's dietary needs had been assessed and were part of their care plan. Each person's dietary needs were recorded in their care plan and the chef had information about people's special or preferred diets. For example, one person wanted no dairy products, this was recorded and the person told us they were not given those dairy products. Where people had been identified at risk of dehydration or malnutrition this was closely monitored and concerns were followed up appropriately.

People were frequently encouraged to have drinks and there were cold drinks readily available for people in the lounge area and in people's bedrooms. Staff were regularly recording what drinks and food people had taken. One person confirmed they had food available throughout the day and they never went hungry. One person was seen helping themselves to fresh fruit which was available in the lounge.

Requires Improvement

Is the service caring?

Our findings

People did not always receive a service which promoted their privacy and dignity. One person was shouting within earshot of other people when wanting the toilet and there were no staff in the vicinity to respond and no call bell within their reach. A staff asked a different person, in front of people, if they wanted to go to the toilet in a way which undermined their dignity. Some people's clothes did not appear to have been ironed and the people looked unkempt. We had been informed that other people's clothes could be found in people's drawers although they were labelled; we found one example. There were many examples of people's clothes being creased because they were squashed into drawers. The registered manager twice suggested we talk to people in a person's bedroom. They said the person would not mind but they had not asked their permission. One person had chosen to keep the key to their room and kept it locked for their privacy and independence.

There were signs throughout the home, which informed staff how to work, which gave an institutional feel. For example, for hand washing and safe use of chemicals. These notices were not in place to provide people with information and they made the environment less homely in appearance. The PIR stated that no staff had received training in dignity, respect or person centred care.

It was not clear people were supported to express their views and be actively involved in making decisions about their care. There had been three monthly resident meetings which covered day to day information such as preferred times for retiring to bed and what they would like included on the supper menu. Families said care plans had been discussed with them. However, care plans were signed by the registered manager without any reference to the person to whom the plan belonged, or people involved in their care. Decisions had been made with no reference to any steps being taken to maximise the person's opportunity to express their opinion. This could have been verbally, through staff knowledge of the person or through information provided in a format more easily understood. For example, pictures of food, care or activity options.

People and their families said the staff were caring. Their comments included, "The carers are friendly and kind"; "Staff are lovely", "Most staff are lovely" and "Very polite and helpful."

One family member said, "(Mum) likes it here and she is quite happy." A welcome survey for visitors included the comment, "Staff are very polite and helpful" and a thank you card said, "Thank you for such kindness."

Engagement between staff and people was friendly and often good humoured. People made jokes with staff and some good relationships was evident. A district nurse, asked what the home did best, said staff were "very empathetic and passionate." They said that care was delivered by a "sensitive and empathetic team" when a person had received end of life care and "Their hearts are in the right place". A member of the complex care team also said that end of life care "was handled very sensitively." The family of a very frail person commented that the home had nothing which could be improved and they valued the pressure being taken off the family at that difficult time. One person's care plan included the need for staff to support one person's family who easily became distressed.

The registered manager ensured that people's needs were understood and met when end of life care was delivered. A district nurse said they were contacted quickly with any concerns and their advice was followed. Necessary equipment was in place and arrangements were in place to manage any pain or distress should this arise.

Requires Improvement

Is the service responsive?

Our findings

Staff tried to provide care that was responsive to people's needs. For example, one person was supported to continue their hobby of gardening and another was assisted to go shopping and read books. There were regular activities at the home such as painting and ball games. Staff told us they would take people out into the community and encouraged people to go for walks, but most were reluctant to go out. Most people had a written history to inform staff about their past, interests, hobbies and any faith and cultural needs. However, the activities we saw recorded were not based on a plan from that information and were not person centred. The PIR stated that staff had not received training in person centred care.

Care plans are a tool used to inform and direct staff about people's health and social care needs and each person had such a plan. Those plans included some detailed information and were regularly reviewed but there was nothing to suggest the person had been involved in their plan. Care was not task led because staff had the time to spend with people but neither were staff always actively supporting what the person needed to promote their well-being. For example, one person was said by their family to have always been extremely smartly dressed, always wearing a white shirt and clean shaven. Their care plan said they could shave themselves but might need assistance. Consequently they were not clean shaven and staff had not explored ways of supporting them with this whilst encouraging their independence.

Staff regularly updated people's care records, which included monitoring their health and well-being. This included any falls, incidents and details of diet taken and weight monitoring so that any concerns could be identified. The staff were said to be "Much more proactive" and there was "Significant improvement" with regard to skin protection. However, it was felt by some health and social care professionals that the home accepted people with needs which were too demanding for the home. The registered manager said they always assessed people's needs prior to admission, and agreed that they would try hard to accept people requiring a care home environment.

Efforts had been made to get the views of people using the service, their families and health care professionals. However, the registered manager felt the responses to their feedback survey had been "extremely poor" and they recognised this had not been a success. The PIR stated that there were 'regular residents meetings where service users can make their preferred choices known so they could be responded to these accordingly'. The PIR stated there had been two complaints in the last 12 months both dealt with and the registered manager said there had been no recent complaints. One person's family felt the care was "a bit better" since they had a word with one of the staff but they still could not find a photograph which they presumed had been "put away in a drawer somewhere". People and their families said they felt confident to speak with the registered manager if they had any complaints.

The ambulance service felt that two calls made by Parklands staff to them could have been handled more efficiently. As a result of this a red folder entitled "What is the emergency" was now held in the office on the desk for all staff to check if they had concerns. The registered manager said she hoped this would provide an appropriate service for people and ensure all information was available to such services.

One person had decided Parklands was too rural for them and they wanted to move for that reason. The registered manager was working with the person's social worker to arrange a smooth transition for them.

Requires Improvement

Is the service well-led?

Our findings

Parklands Residential Home is one of two care homes run by the organisation YMICARE Limited. The person registered to oversee the standards at both homes has regular contact with Parklands and was present during the second day of our inspection, auditing the service.

A positive and empowering culture had not been achieved at Parklands. Staff did not feel they were actively involved in developing the service and some expressed their dissatisfaction with the registered provider because they felt the work they did was not always valued. For example, a recognition of the value of the senior care worker's role. There were no negative comments about the registered manager from staff or people using the service and one described the home as "very well organised." The registered manager kept families informed which they appreciated.

The registered manager showed commitment to the people using the service, who responded with a smile and a positive word when she engaged with them. She said she felt well supported in her role. Some health care professionals felt staff at the home "panicked" when people's needs were challenging but they said the registered manager was always approachable and always made the time needed to discuss people's needs. A district nurse said the registered manager worked "incredibly hard to provide a safe and stable environment for people". The PIR stated that the registered manager operated an 'open door' policy and the registered provider visited the home and was accessible to staff.

Different aspects of the service were audited by the registered manager. They included any accidents/falls and medicine management and there were no concerns about those aspects of the service. Safety checks were regularly completed, such as fire safety checks and care plans and risks were regularly reviewed. Information of concern from a whistle blower had led to an unannounced visit to the home by the registered manager and disciplinary action followed where poor practice had been found.

Quality monitoring arrangements were not fully effective because they were not identifying where some improvement was required. These included care planning and delivery and the home environment specific to the needs of people living with dementia. Safety and dignity was compromised through staff not being available when needed and staff knowledge did not equip them for the complex needs of some people using the service. The registered manager and the provider were not recognising where these improvements were needed. The registered manager felt health care professionals had not made clear where they had concerns.

This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered provider was improving the service through a programme of environmental upgrading. For example, nine bedrooms were redecorated to reduce a risk of injury to residents and staff. A new commercial double oven was fitted to replace the existing broken domestic oven which included improved electrical supply to the kitchen. All the doors were fitted with new locks and floors had been resealed and repaired. The mains water supply to the home needed substantial maintenance. The provider was very receptive to improving the environment in line with good practice guidelines in environments for people living with dementia and stated a commitment to addressing any concerns about the service at Parklands. However, there was not a shared understanding of the key challenges, achievements, concerns, risks and of finding ways to motivate and support the staff and registered manager.

The home was meeting its conditions of registration and the CQC was kept informed and notified of events as necessary.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not always protect people through effective assessment and monitoring of the quality of the service provided.** **Regulation 10 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **There were not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people using the service in relation to their care.** **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care was not planned and delivered in a way which protected people from the risk of receiving treatment that is inappropriate or unsafe.** **Regulation 9 (1) (b) (i) (ii) (iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

This section is primarily information for the provider

Action we have told the provider to take

People were not protected from the risk of acquiring an infection because aspects of the home environment were not maintained to an appropriate standard of cleanliness and hygiene.

Regulation 12 (1) (2) (c) (I)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff There were not suitable arrangements in place to ensure that staff received appropriate training to deliver care safely, and in accordance with people's needs. Regulation 23 (1) (a)