Anchor Carehomes Limited

Savile Park

Inspection report

1 Mellor Street
Halifax
West Yorkshire
HX1 3AE

Tel: 01422399863
Website: www.anchor.org.uk

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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**

Summary of findings

Overall summary

This inspection took place on 8 August 2017 and was unannounced.

At our last inspection we rated the service as 'good' overall, and made a recommendation; 'We recommend management continue to ensure improvements to the service continue and are sustained to ensure a consistent, high quality service.' We did not identify any breaches of regulation. Since that inspection the provider (owner) of the home and management team had changed.

Savile Park is a care home with accommodation over three floors connected by lifts. Each floor has en suite rooms and living and dining areas. There are private gardens which can be accessed from the ground floor lounge and some people's rooms. On the day of our inspection there were 54 people using the service, some of whom were living with dementia.

There was a registered manager in post on the day of our 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.

We identified some concerns in relation to the storage and administration of medicines. Some medicines were found unattended in people's rooms, and there were not always guidelines in place to ensure people received 'as and when' medicines, for example for pain relief, appropriately. We found stocks of medicines matched records.

Risks associated with people's care and support were documented, however we found the guidance for staff was not always sufficient to ensure these risks were fully minimised. The safety of the premises was well managed, however we identified malodours in some areas of the home.

Safeguarding was understood by staff who knew how to report any concerns. Accidents and incidents were well managed, with reports to the local authority and the Care Quality Commission being made as required.

Staff were recruited safely, although we found they were not always deployed in sufficient numbers. The registered manager had already identified this and we saw it was an item included in their action plan.

We found mental capacity and deprivation of liberty safeguards (DoLS) were not always fully understood or appropriately documented..

We saw there was a comprehensive training programme for staff, and people told us they had confidence in the abilities of the staff to provide effective care. People had timely access to health and social care professionals when this was needed. Staff had supervision and appraisal meetings to provide support, although feedback about the effectiveness of this was mixed.

People were positive about the food served at Savile Park, and we saw people received the support they needed. Kitchen staff had good knowledge about dietary requirements and ensured specialist dietary needs (for example for people who needed a soft diet) were well catered for. . There were snacks and drinks available at all times.

People told us the staff were caring and respectful of their privacy and dignity. Our observations highlighted inconsistencies in staff practice, however. We saw examples of good practice such as knocking on doors and speaking kindly with people. We also saw staff discuss people without consideration of their privacy and some delays in personal care being attended to. Care plans did not always contain sufficient detail about people's preferences for care, although some people felt they had been consulted in the writing of their care plans.

Care plans were reviewed, however we found they were not always completed with sufficient or up to date information to ensure care was always responsive. Information about people's interests was not always used in planning activities for them, and not all people were informed about what activities were taking place on the day of our inspection. There was a mix of feedback about the quality of activities in the home.

People felt confident in raising complaints or concerns, and we saw these were well managed. The registered manager invited people and their relatives to meetings to give feedback about the service.

We received positive feedback about the registered manager and the experience of living and working at Savile Park. There were processes in place to measure, monitor and improve the quality of the service, although we saw actions were not always completed in a timely way.

We identified two breaches of regulation during this inspection. You can see what action we have told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

We found some concerns in relation to medicines administration and storage.

People felt safe, and we saw the home was mainly well-maintained and clean. However, there were malodours on two floors of the home and some furnishings were not always cleaned effectively.

Staff were recruited safely and understood how to safeguard people from the risk of abuse. Staffing levels were under review.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to make decisions was not always appropriately documented, and we found some staff required additional training to ensure mental capacity and deprivation of liberty safeguards (DoLS) were managed effectively.

Staff received comprehensive training, however supervision and appraisal meetings were not always effective in providing on-going support and development.

People received good support with access to healthcare professionals and nutrition and hydration. Care plans for nutrition lacked some detail about people's preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

There was inconsistent caring practice in relation to privacy and dignity.

Some care plans lacked detail relating to people's preferences for care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were regularly reviewed, however we found they were not always updated as needed to reflect people's current care needs.

There were effective processes in place to manage and respond to complaints and concerns.

There were activities for people to participate in, however we found people were not always offered the opportunity to participate.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

We received good feedback about the registered manager, and saw they were a known presence in the home. People were involved in the running of the home.

There was a system of audit and action plans in place, however further improvements were still required to ensure the quality of the service was consistent. We saw some actions were not taken in a timely manner.

Savile Park

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 checked 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 took place on 8 August 2017 and was unannounced. The inspection team consisted of two adult social care inspectors, a registrations inspector and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all the information we held about the service, including notifications sent to the Care Quality Commission. Notifications relate to incidents at the home that the provider has a legal duty to report to us. We also contacted other bodies including the local authority commissioning and safeguarding teams, Healthwatch and the fire and rescue service to ask for any information they held about Savile Park. Healthwatch is a body which gathers information about people's experiences of health and social care in England. We did not receive any information of concern.

Before the inspection we requested a provider information return (PIR), which was returned to us in May 2017. A PIR 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.

During the inspection we spoke with the registered manager, the area manager, two deputy managers, six members of care staff, the chef, kitchen assistant and the activities co-ordinator. We also spent time looking round the service, including visiting all communal areas, the kitchens, communal bathrooms and toilets, and some private bedrooms with people's permission. We spoke with 11 people who used the service, ten visitors and one visiting health professional.

We looked at records relating to management of care and the premises including six care plans, four staff files, maintenance certificates, records of audits and checks and meeting minutes.

Requires Improvement

Is the service safe?

Our findings

All the people and visitors we spoke to told us people receive their medication on time and most told us people received pain relief when needed, however we found medicines management was not always safe.

We observed medicines being administered on two floors, and saw the staff member on each told people it was time for their medicines, and assisted them patiently. People were asked if they needed pain relief. However, on the second floor unit we saw one person had removed the tablet from their mouth and put it on the dining table, and we found another person's entire morning dose of tablets stuck onto their bedding. A visitor told us they had occasionally seen tablets on their relative's floor. They said, "It looked as if [name of person] had dropped them when they were taking them. The staff might not have noticed." These examples meant staff were not always making appropriate checks that people had taken their medicines.

Medicine trolleys and stocks of medicines for the first and second floor were kept in a clinic room on the second floor. We saw one of the cupboards for storing medicines had its doors wide open. Staff told us the lock to this cupboard was broken. Another cupboard in which medicines were stored did not have a door on it at all. We found the medicines fridge which held a bottle of tablets was unlocked with the key in the fridge. Temperatures of storage of medicines were taken but this was not consistently done on a daily basis with gaps of up to a week which meant the provider could not be certain that medicines were stored at appropriate temperatures at all times. Our checks on medicines management on the ground floor were satisfactory.
Some protocols were in place for medicines prescribed on an 'as required' (PRN) basis, but this was not consistent. For example, protocols were not in place for PRN Paracetamol. We saw for one person, who was receiving regular Paracetamol; the effectiveness of these was not being recorded.

We saw the first aid kit and burns kit was stored in a very high cupboard in the second floor clinic room. We struggled to reach the cupboard which resulted in the first aid kit container falling out. We saw one of the closing mechanisms on the box was broken. The burns kit contained a number of dressings all with an expiry date of June 2015. This meant items in the first aid box may not have been safe to use.

Where risks to people's personal safety had been identified, a risk assessment was in place within the care plan. However, we found these were often generic and lacking in detail to show how staff could minimise those risks. For example, falls risk assessments stated the risk minimisation measures as, 'To ensure all equipment is used regularly and checked, this will prevent (person) from having re-occurring falls'. No list of the equipment used by the person was included and the risk assessments did not consider such as footwear or side effects of medicines. Care plans which showed people needed a hoist and sling to transfer simply advised staff to use the correct sling, without containing any information about what type of sling that was. This meant people could be put at risk of falling or discomfort.

These examples demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were mostly supplied within a monitored dose system with others supplied in boxes. Medication Administration Record sheets (MARs) showed medicines received into the home were counted with the amount received recorded. We checked a sample of boxed medicines against the amounts recorded as received and administered and found these concurred. MARs contained a photograph of the person to aid recognition and ensure medicines were given to the correct person. Any allergies were also noted on the MAR.

Some medicines require additional secure storage and management because of the nature of the drugs they contain. These are also known as 'controlled drugs'. There were no issues with the management of these medicines.

People we spoke with told us they felt safe living at Savile Park. Comments included, "I feel safe here because I have no problems. The place just makes me feel safe," "It's definitely safe. When I go out I can lock my door. I have my own key to my room," "I know people and feel safe," and "I do feel safe here, the staff are very helpful."

People visiting friends and relatives also said people were safe. One relative told us, "There is always someone here to ask for help and staff are really protective." Another said, "[Name of person] loves it here, she calls it 'home'." In addition people confirmed they felt safe around other people living in the home, and told us they had access to working call bells if they needed assistance in their rooms.

All the people we spoke to told us the home was kept clean. However, one visitor we spoke with told us, "It is not always clean. Generally it is, but sometimes there is a smell of urine and the toilet in my relative's room was dirty today. We noticed there was a smell of urine on the top floor today." We found the building was generally well maintained and clean, however we noted the presence of some malodours on the middle and second floors, saw some chairs and tables in dining areas had an accumulation of feed debris on them and saw a number of toilet roll holders were broken. Although toilet roll was available, it was not within easy reach. We brought these examples to the attention of the registered manager and area manager, and asked them to take action.

Systems were in place to ensure the safety of the building. We saw up to date certificates and records of checks made on such as water safety, emergency lighting, fire safety, lifting equipment and gas safety. The most recent electrical condition report was being followed up within the company due to the identification of some minor issues.

People were protected from the risk of abuse or harm because staff could describe to us how they would identify anyone at risk of abuse and what their responsibilities were in reporting their concerns. We saw all accidents and incidents were monitored and audited by the registered manager on a monthly basis with reference to the type, time and location of the accident or incident. Where any themes had emerged, action had been taken to try to reduce the risk. Our review of incidents showed safeguardings were recognised and correctly reported.

All of the care files we looked at included personal emergency evacuation plans (PEEPs). Whilst the PEEPs gave details of the mobility needs of the individual in the case of an emergency, they did not consider how people, particularly those living with dementia, might react in the case of an emergency and the support they would need.

Staff were recruited safely. We saw full records were kept including the application form, notes made during interviews and evidence staff's identity was checked before their employment commenced. In addition the

provider made checks with former employers for references, and with the Disclosure and Barring Service (DBS) to ensure prospective staff were not barred from working with vulnerable people. Checks such as these help employers make safer recruitment decisions.

We received some mixed feedback when we asked people and visitors whether there were always sufficient staff on duty. Most people who used the service felt there were, using comments such as, "Loads of staff about," "There are always staff around, night and day. You only wait a minute or so and they come," and "At the moment I think there are enough staff." A visitor told us, "I don't think there is ever enough staff really, they could always do with more, some of the people here are very dependent and will need more help." Another visitor told us they sometimes wondered where all the staff were when they came, but that this was not always the case. People we spoke with told us they did not usually have to wait long when they needed assistance.

We reviewed rotas and made observations during out inspection relating to staffing in the home. We discussed our findings with the registered manager, as we were concerned that there had not always been sufficient staff to meet people's needs. The registered manager and area manager showed us correspondence and action plans which evidenced they had recognised this as an issue and had begun to take action. For example, they were in the process of recruiting specific staff to lead activities, which were currently being led by care staff on the day of our inspection.

Requires Improvement

Is the service effective?

Our findings

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 saw mental capacity assessments had taken place and where people had been assessed as lacking capacity DoLS applications had been made. Some best interest meetings had been recorded, however these lacked specific detail about the discussion and what people involved had contributed. We also saw some best interest decisions, for example one relating to a bed and chair sensor, which only evidenced the deputy manager had been involved in the decision making process.. This meant the decision had not been made in line with the requirements of the MCA.

Although staff had received training in the MCA and DoLS, some staff did not fully understand the implications of a person having a DoLS in place. One member of staff said, "A DoLS is to keep people safe," but could not explain further. We also found the members of the management team assessing and managing capacity and consent did not always fully understand the processes involved, and concluded additional support and guidance was needed. This was fed back to the management team during our inspection.

For example, one person's care plan indicated they had capacity but could not give consent to care and treatment due to a sensory disability, and that a DoLS application had been made on this basis. We brought this to the attention of the registered manager as the person's disability did not mean they could not consent to their care and treatment. The capacity assessment had wrongly concluded that the sensory impairment met the criteria to indicate the person had an impairment or disturbance in the functioning of the brain.

We also saw a best interests decision in care plan for the use of a sensor mat, which had been put in place to minimise the person's falls risk. We spoke with the deputy manager about this, as the person had capacity and would have been able to consent to this themselves. They told us it was their understanding that a best interests' decision had to be completed for anyone with a sensor mat in place.

We concluded the provider was in breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed records relating to DoLS. We saw the registered manager had submitted applications for DoLS

when these were required, and had applied for renewals of these in a timely way.
Most people we spoke with told us their choices were respected by staff. We saw people getting up at times which they preferred, and saw documentation relating to preferences for either male of female staff to assist with personal care was included with care plans. People told us this was respected. One person told us they had been offered the chance to move when a room had become available on a lower floor. We saw people were asked what they wanted for breakfast and lunch, and where people needed assistance with these choices we saw staff show them plated meals to aid their recognition and selection.

People and relatives told us they were confident in the staff's abilities to provide effective care and support. One person told us, "As far as I can see they are trained to do the job." Another person said, "They have training days. I've seen them in room lots of times, so I think that's what they are doing." A relative told us, "Some staff are very good, there is a lot of repetitive behaviour but staff deal with this well."

We reviewed records of training and saw there was a comprehensive programme in place which included moving and handling, fire safety, dementia awareness, equality and diversity and safe administration of medicines. There was a process in place to ensure this training was kept up to date.

When asked about support, staff gave mixed feedback. One member of staff told us, "Supervision is one-sided, and any concerns I raise are not always actioned. I don't always get feedback about them." Another member of staff we spoke with gave more positive feedback about the processes. They told us they felt included in the process and said training they requested was provided. We saw records which confirmed there was a programme of supervision and appraisal activities in place, the process was usually used to pass operational information to staff, rather than discuss their individual performance and development needs. We discussed this with the registered manager, who told us this was an area identified as needing improvement. They showed us this was an action in the service development plan which they and the area manager were working on.

People and their relatives told us people had prompt access to health and social care professionals when this was necessary, and records in people's care plans confirmed this. We saw records of visit to or by GPs, district nurses, opticians, chiropodists, dieticians and the falls team.

People were positive about the food served at Savile Park. One person told us, "The food is very good, you get enough and there is a written menu." Another person said, "There is always enough, a choice and an alternative. It's something different every day." A third person told us they had been involved in planning the menus, as they had spoken with the chef when they asked for suggestions. We saw evidence the meals and menus were discussed at a resident's meeting with the registered manager.

The chef had access to information relating to people's dietary needs, and we saw they paid attention to making meals look appetising when they needed to be blended for people at risk of choking. For example, we saw potatoes served for lunch had been piped after blending, and each component of the meal had been arranged separately on the plate.

We made observations during the breakfast and lunch services on the day of the inspection. People received the assistance they needed in order to choose and eat their meals. For example, we saw some people used adapted crockery to help them remain independent with eating. We saw staff ask people before providing them with assistance to cut up food or to eat their meal.

Care plans were in place for nutrition, however we found these often lacked detail of people's likes and dislikes, and what actions needed to be taken if staff had concerns about a person's nutrition. For example,

we saw some care plans stated, 'Team leader to ensure relevant health care professionals,' rather than giving detail of the circumstances which would trigger a referral to the dietician or GP.

People told us they had access to snacks and drinks at all times. One person said, "There is always fresh water or juice. [The staff] bring me a drink mid-morning and afternoon, and if I want a cup of tea in between I just press my buzzer and they bring me one. I have drinks when I want." We saw people had access to snacks throughout the day. These included pastries, cake and fresh fruit including pineapple, water melon and strawberries.

Requires Improvement

Is the service caring?

Our findings

Care plans did not always contain sufficient detail to ensure staff would know how to support people in ways which met their needs and preferences. For example, one person's mobility care plan contained conflicting information about the support the person needed in order to mobilise safely. It was variously stated the person walked using a stick, required two staff to assist them to walk, used a wheelchair, and needed a hoist or standing hoist to assist them to transfer from a seated to standing position. This meant the person may not have received appropriate support.

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

People told us their privacy and dignity were respected, and we did see examples of this during our inspection. We saw staff refer to people by name, knock on doors before entering rooms and put themselves at people's eye level when speaking to people who were sitting down. However, we also observed some instances where people's dignity was not always considered. For example, we observed staff frequently spoke about people using the service openly and within the hearing of other people, and during lunch when staff were supporting people to eat their meals we saw they frequently chatted amongst themselves instead of the person they were supporting. We also saw one person had spilled a drink on themselves, which had left their clothing very wet. Staff did not notice this until we drew their attention to it. Once we had alerted staff, they supported the person to get changed.

People we spoke with told us they had a good relationship with staff, who they described as 'kind' and caring. One person told us, "[They are] super staff, very caring. Every one of them." Another person said, "Most of them are very good, they chat to me about what I want." Another person said, "[They are] very good staff, always have a smile on their face and ready to have a little talk with you if you want to. I had to leave the last home I was in and was upset and worried because the staff there were so lovely, but they are just as lovely here." A visiting relative told us, "The staff know [name of person] and what's she's like. She likes cuddles and they give her cuddles. That's nice, and that's how I know they look after her."

We saw care plans contained a document called, 'My Life Story', which contained information which would be of use to staff in forming stronger relationships with people who used the service. This is particularly important when communication may be difficult due to people living with dementia. This information included details of cherished memories, significant people in their lives and important life events. We saw people's families had assisted in the preparation of some of these documents.

People we spoke with said they were helped to maintain their independence. One person told us, "My mobility has deteriorated but staff encourage me to walk as much as I can and walk me to the end of the corridor." A visiting relative said, "The staff know [name of person] and how to get her better. She fell and fractured her hip, and they really helped to get her walking again." During the morning of our inspection we saw some people were able to use the kitchen facilities in the dining areas to make their own drinks as they got up.

Some relatives and people who used the service told us they felt they had been involved in planning their care. One person told us he had been involved in discussing preferences for care should their medical condition deteriorate in the future. This included recording their preference to remain at Savile Park for care, rather than be admitted to hospital. Other people we spoke with said they had also been able to discuss future wishes for care.

We saw people's rooms were personalised with people's own items and family photographs. Where people had Do Not Resuscitate (DNACPR) forms in their care plans we saw discrete use of symbols on people's doors to remind staff of this. Another symbol alerted staff to the person having a DoLS in place. This meant staff had access to key information about people at times when they may need it, whilst people's privacy and dignity were protected.

Requires Improvement

Is the service responsive?

Our findings

We saw evidence in care plans that the provider carried out an assessment of people's needs before they began using the service. This is important in ensuring the service can meet those needs.

The pre-assessment was used as the basis for preparing a series of care plans which showed how people's care and support needs would be met, however we found these did not always contain sufficient detail. For example, a care plan for a person's physical condition included a number of medical terms and said, 'staff to understand [name of person]'s conditions and how they affect [name of person]'s day to day life.' The care plan gave no detail of what the effects of the condition might be. We asked a member of care staff if they understood the medical condition and the care plan, and they told us they didn't. Another care plan for anti-coagulant (blood thinning medicines) therapy instructed staff to report 'changes' but gave no detail about how anti-coagulants might affect the person.

We spoke with a visiting health professional who told the registered manager and staff knew people well, and followed their advice when it was given. We saw care plans contained signatures of staff to confirm they were reviewed regularly, however changes were not always made to show they represented people's up to date needs. For example, we saw someone had been losing weight over the previous five months, and although the registered manager told us this had been discussed with the person's GP, there was no evidence of any update to the care plan to show what advice had been given or how staff should act to prevent further weight loss. This meant the service may not always have been responsive to changes in people's conditions or needs.

These examples contributed to our conclusion the provider was in breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about people's interests and hobbies was not always used to promote a stimulating environment for them. For example, we saw in one person's care plan they liked sport, especially rugby and cricket. We spoke with the person, and they told us they still enjoyed these and other sports. When we asked staff what they did to support this person to enjoy these sports they told us they did not know the person liked them, but knew they liked tennis. We asked if staff looked at television listings so they could support the person to watch sport on television if they were unable to go out to see such activities. Staff told us they didn't.

Some people told us they were involved in reviews of their care plans, and we saw families were invited to participate in reviews during the year. We noted consent from people to involve families in this way was not always recorded, and brought this to the attention of the registered manager.

During our inspection we heard call bells in use, and noted staff were responsive to these. People we spoke with said they received assistance when they needed it.

We received mixed feedback about the level of activities in the home. One person told us, "There is not

enough to do to keep me occupied." Another person said, "There hasn't been much to do until recently, when they get people together from all floors. I don't always get to know when things are going to happen." A third person told us, "They consult us about what we like doing and we are involved all the time." Some people and their relatives said there was enough to do. One relative told us there had been a family curry night. They said, "They seem to want to involve families."

The registered manager told us they had changed their approach to providing activities for people. These now took place on the middle floor, with people from other floors invited to join them. The registered manager told us this was to improve the community feeling in the home. On the day of our inspection we observed that not all people were told about the activities taking place or invited to take part. People who did not attend the activities were often observed to be lacking in activity.

On the day of our inspection we observed a gentle exercise and music session, which 14 people attended. We saw a high level of engagement with the activity. After the session was concluded drinks and snacks were served. Some people were supported to maintain interests outside the home. Some people were still attending their own churches, and other people mentioned activities such as being supported to go to the bank and to attend social clubs.

There were policies and procedures in place to ensure complaints and concerns were responded to appropriately, and records we looked at confirmed these were being followed. People and their relatives said they would feel confident in raising any concerns. People who had done so said they felt their complaints had been dealt with effectively.

People and their families had opportunities to meet with the registered manager and discuss the service. We saw in the most recent resident and relative meeting minutes there had been a meaningful discussion about food served in the home, for example people requested a choice of brown as well as white bread for sandwiches, changes in the timing of serving of snacks and changes to the menu to ensure it met some people's cultural preferences. We also saw activities and trips were discussed. The date of the next meeting was being advertised, and we saw notices encouraging people and relatives to attend to give feedback about how the home was progressing. This meant the provider was actively trying to involve people in the running of the home.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we rated this key question as 'requires improvement'. We did not identify any breaches of regulations. Since our last inspection the provider (owner) of the home and management team had changed.

There was a registered manager in post when we inspected. They were supported by the area manager, two deputy managers, team leaders and care staff. People we spoke with were happy with the way the service was being managed. One person told us, "Yes, it is well managed. They don't have a big turnover of staff." Another person gave examples of why they felt there was good management in the home. They said, "If you have a problem you can tell someone. You are treated with respect, and the atmosphere is relaxed and friendly." We observed the registered manager knew residents well, and saw they spent time working alongside staff. Although not all people who used the service could tell us who the registered manager was, we found all visiting relatives could name the person and found them approachable.

Staff also gave positive feedback about the management of Savile Park and their experience of working there. One staff member told us, "[Registered Manager] is lovely, she will bend over backwards to help you and I feel well supported." Another staff member said, "[The registered manager] is easy to talk to and approachable."

We looked at records of accidents and incidents in the home, and saw these were being managed and reviewed appropriately. Any safeguarding incidents were being reported to the local authority, and the registered manager told us they checked with the safeguarding team if they were not sure incidents met the threshold for reporting. Some incidents have to be reported to the Care Quality Commission, and we saw these reports were being made as required.

There were processes in place to measure, monitor and improve the quality of the service. People who used the service were encouraged to give feedback via meetings and surveys, and had regular contact with the registered manager. The area manager was also a regular presence in the home, and worked with the registered manager on a rolling action plan, which we saw contained information about improvements needed, who would ensure action was taken and by when. Although there was evidence the management team were identifying actions, we saw these were not always taken in a timely way. We saw care plans were audited and we saw a number of issues were raised through the audit process. However, we did not see any managerial overview of the care plan audits and did not see evidence of how the identified issues had been addressed.
We fed this back to the area manager and registered manager as an area for improvement at the end of our inspection.

There was a programme of audits in place to assist the registered manager gather information about quality in the service, and although this was being followed and had identified a number of issues to take forward, we found a number of areas in the home where improvement was still needed. The registered manager and area manager were candid in our discussions about this. The registered manager told us, "An inspection is

another opportunity to learn about where you are and where you need to go. We had a lot of work to do to get the home into shape, and we know we've still some work to do." We recommended the provider take action to ensure governance activities were sufficiently robust to ensure required improvements were made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's capacity to make decisions was not always appropriately documented, and we found some staff required additional training to ensure mental capacity and deprivation of liberty safeguards (DoLS) were managed effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Care plans did not always contain sufficient personalised and up to date information to enable staff to provide care safely.