Care Quality Commission

Charing Gardens Limited

Park View Care Home

Inspection report

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Ratings

Overall rating for this service	Good
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?	Good

Overall summary

The inspection was carried out on 4 December 2015 and was unannounced.

The service provided accommodation and personal care for older people who are living with dementia. The accommodation was provided over two floors and in a linked detached ten-bedded annex. A lift was available to take people between floors. There were 42 people living in the service when we inspected.

There was a registered manager employed at the service. 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.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Restrictions imposed on people were only considered after their ability to make individual decisions had been assessed as required under the Mental Capacity Act (2005) Code of Practice.

Summary of findings

The registered manager understood when an application should be made. Decisions people made about their care or medical treatment were dealt with lawfully and fully recorded.

There were systems in place to assess the levels of staff needed to meet people's needs. However, we found that staffing levels had not kept pace with the levels of care people needed as their dementia deteriorated and their needs changed. This had resulted in people who needed more supervision to keep them and others safe were being exposed to potential harm as staff were not always available in the annex.

Recruitment policies were in place. The policy reflected best practice and the law in relation to pre-employment checks. However, the registered manager had not always applied the policy when new staff were recruited to work in the service.

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

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

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

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

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

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

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

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

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

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

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

People felt that the service was well led. They told us that managers were approachable and listened to their views. The registered manager of the service and other senior managers provided good leadership. The provider and registered manager developed business plans to improve the service. This was reflected in the positive feedback given about staff by the people who experienced care from them.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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.

Staff were not always available in the right numbers to meet people's assessed needs. Recruitment procedures were in place, but checks on new staff were not robust.

Risks were assessed and recorded. Medicines were managed and administered safely. Incidents and accidents were recorded and monitored to reduce risk. The premises and equipment were maintained to protected people from harm and minimise the risk of accidents.

People experienced a service that made them feel safe. Staff knew what they should do to identify and raise safeguarding concerns. The registered manager acted on safeguarding concerns and notified the appropriate agencies.

Is the service effective?

Good

The service was effective.

People were cared for by staff who knew their needs well. Staff understood their responsibility to help people maintain their health and wellbeing. Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

Staff received an induction and training and were supported to carry out their roles well. The Mental Capacity Act and Deprivation of Liberty Safeguards was followed by staff.

Is the service caring?

Good

The service was caring.

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

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

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People were provided with care when they needed it based on a care plan about them.

Summary of findings

Information about people was updated often and with their involvement so that staff only provided care that was up to date. People accessed urgent medical attention or referrals to health care specialists when needed.

People were encouraged to raise any issues they were unhappy about and the registered manager listened to people's concerns. Complaints were resolved for people to their satisfaction.

Is the service well-led?

Good

The service was well led.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered.

The provider and registered manager promoted person centred values within the service. People were asked their views about the quality of all aspects of the service.

Staff were informed and enthusiastic about delivering quality care. They were supported to do this on a day to day basis by leaders within the service.

Park View Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 4 December 2015 and was unannounced. The inspection team consisted of two inspectors and one expert by experience. The expert-by-experience had a background in caring for elderly people and understood how this type of service worked.

Before to the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law. We took into account information of concerns we had received before the inspection from a whistleblower.

We observed the care provided to people who were unable to verbally tell us about their experiences. We spoke with eleven people and four relatives about their experience of the service. We spoke with thirteen staff including the current registered manager, the new manager, the head of care, four senior care workers, six care workers to gain their views about the service. We asked four health and social care professionals for their views about the service.

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

This was the first comprehensive ratings inspection for this service since registration in August 2013.

Requires improvement

Is the service safe?

Our findings

People described a service that was safe. People said, "I like it here and people are kind. I can walk around then find someone to talk to". And "They (staff) make this place come to life and I feel cherished and safe." Another person told us that they trusted the staff and that they treated her like family". Other people told us how they would, "Talk to the registered manager if they had any concerns".

Relatives told us that they felt that their family members were safe and secure. One who visited his wife every day said, "I help my wife settle, she is safe and secure here."

Staffing levels were not always planned to meet people's needs and staff were not always deployed in appropriate numbers within the service to keep people safe at all times. People told us that at times there were not enough staff in the annex. This had also been acknowledged within the staff team who had raised this at a recent team meeting. A visiting health and social care professional expressed their concerns to us about the staffing levels in the annex.

One relative we spoke with raised concerns with us about there not always being enough staff in the annex. They were concerned about people's safety. They said, "If someone rang an emergency bell there is sometimes no staff here (In the annex) on duty and it could be a real issue."

In addition to the registered manager and head of care there were eight staff available to deliver care between 7 am and 9 pm. They were managed by two senior care workers during the day. At night there were three staff delivering care managed by a senior care worker. There were no dedicated staff deployed to the annex overnight as cover was provided as required from the main service staff team. We found that the system in place to assess the staffing levels people needed who lived in the annex was not effective. For example, we could see from people's care plans and risk assessments that as people's dementia had changed they needed higher levels of staff supervision and protection in the annex area.

We observed that people in the ten bedded annex were left without staff support or supervision for short periods of time. Staffing in the annex was limited to one member of staff at times during our inspection. The member of staff often had to leave the annex to get paperwork or other supplies from the main service and there were no back-up systems operating to cover the annex. We discussed this with the registered manager. They told us that people's care needs in the annex were low, but that there were concerns about how quickly people could be found placements that met their needs as their dementia developed. In some cases, people's behaviours had become more challenging to others. We found that the registered manager had not planned the staffing in the annex to take account of people's needs and new risks they faced as the effects of their dementia changed their behaviours. For example, we observed a heated verbal altercation between two people in the annex when there were no staff present. This put people at risk of physical and emotional harm without staff being able to intervene and prevent aggressive behaviours from escalating. In addition, it took longer for staff to respond to nurse call bells when sounded in the annex than in the main building. In one instance we noted a call bell alarm sounding from the annex for at least eight minutes. This meant that staff were not available to respond to people's needs or if people or staff in the annex needed urgent help.

This was in breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised our concerns about staffing levels in the annex with the registered manager and they responded by increasing the number of staff in the annex and by putting a system in place to ensure there would be a staff member in the annex at all times.

People were at risk of receiving care from staff whose suitability had not been fully checked. The registered manager had access to a policy, which addressed all of the things they needed to consider when recruiting a new employee. However, we found that two staff who had recently been employed to work at the service did not have suitable references from their last employer. In one case, the applicant had stated on their application form they had been working for another adult social care provider, but they had not included this organisation as a reference. We spoke to the registered manager about this and they told us these staff had worked in the service for an agency that would not provide a work reference for them. This presented a risk to people who needed safeguarding which should have been taken into account by the registered manager as part of the recruitment process.

Requires improvement

Is the service safe?

This was in breach of regulation 19 (1) (a) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff had been through an interview and selection process. Applicants for jobs had completed applications and been interviewed for roles within the service. New staff could not be offered positions unless they had proof of identity and confirmation of previous training and qualifications. All new staff had been checked against the disclosure and barring service (DBS) records. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed safeguarding.

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

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

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

Incidents and accidents records were checked by the registered manager to make sure that responses were effective and to see if any changes could be made to prevent incidents happening again. If people had falls, this was fully recoded so that patterns and frequency could be monitored with actions taken to minimise the risks.

People were cared for in a safe environment and equipment was provided for those who could not weight bear so that they could be moved safely. Equipment was serviced and staff were trained how to use it. The premises were designed for people's needs, with signage that was easy to understand. The premises were maintained to protect people's safety. The maintenance records showed that faults were recorded, reported and repaired in a timely manner. There were adaptations within the premises like ramps to reduce the risk of people falling or tripping.

People were protected from the risks associated with the management of medicines. Appropriate assessments had been undertaken for people around their ability to take their medicines and whether they had capacity to make informed choices about medicines. Staff who administered medicines received regular training and yearly updates. Their competence was also assessed by the head of care to ensure the medicines were given to people safely. Staff administering medicines did this uninterrupted as other staff were on hand to meet people's needs. Staff knew how to respond when a person did not wish to take their medicine. Staff understood how to keep people safe when administering medicines.

There was an up to date medicines policy which staff followed. The policy included the safe management of 'As And When Required Medicines' (PRN), for example paracetamol. There were systems in place to ensure that medicines were always available as prescribed. Medicines were stored securely within a safe, temperature controlled environment. Temperatures were monitored and recorded to protect the effectiveness of the medicines. However, we found that some creams had been stored in a kitchen cupboard in the annex and this cupboard had not been locked. This created a potential risk to people if they accessed the creams.

The system of MAR records allowed for the checking of medicines, which showed that the medicine had been administered at the right times and signed for by the trained staff on shift. The senior carers were responsible for administering medicines and we observed they were doing

Requires improvement

Is the service safe?

this safely. The medicines were dispensed from the medicines room and taken to people or they were transported within the service in a locked metal medicines trolley. The medicines administration record (MAR) sheets had people's pictures on them so that staff could check they were administering the medicines to the correct person. If people refused to take their medicines this was recorded and staff ensured that medicines were safely returned to the pharmacist for disposal.

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

Good

Is the service effective?

Our findings

Staff were trained to meet people's needs and people told us their health and welfare needs were met. One person said, "I am extremely content and happy here, the girls (Staff) are good and they watch us oldies all the time. If I don't feel well, the girls contact the GP who comes within a few days, but if it was more urgent, they would phone the surgery, or take me to hospital".

A relative said "I have confidence that the staff are well trained".

People's health was protected by proper health assessments and the involvement of Health and social care professionals. People had consistent appointments with chiropodist, their GP and the community nursing team. People had accessed the community psychiatric nursing teams to assist staff with the planning and delivery of effective care in relation to their dementia. People had consented to and participated in health protection initiatives such as receiving a flu vaccination. Others had been assisted by nurses from the falls team to try various methods of falls prevention such as walking frames. We observed staff encouraged people to walk with their frames and noted that in doing this staff were following people's recorded care plan. We asked staff about their awareness of people's recorded needs and they were able to describe the individual care needs as recorded in people's care plans. This meant that staff understood how to effectively implement people's assessed needs to protect their health and wellbeing.

Care plans covered risk in relation to older people and tissue viability. The care plans could be cross referenced with risk assessments on file which covered the same area. Waterlow assessments had been completed. (Waterlow assessments are used in care and nursing settings to estimate and prevent risk to people, including from the development of pressure ulcers.) Care plans included eating and drinking assessments and gave clear instructions to staff on how to assist people with eating. People at risk of dehydration or malnutrition were appropriately assessed. People who were at risk of choking had also been assessed. Daily records showed food and fluid intake was monitored and recorded. Care plans detailed people's food preferences.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People could access snacks and hot and cold drinks at any time and tea trolley rounds took place during the day. Staff told us that people could access drinks and snacks at night and that foods like sandwiches were left for people to access. People were weighed regularly and when necessary what people ate and drank was recorded so that their health could be monitored by staff. We saw records of this taking place.

We observed lunch being served in the dining room and in the annex. Food was presented and served in a way that promoted the social aspect of the occasion. People were not rushed. Staff were on hand to supervise and provide support to those people that needed it. People told us that they enjoyed the food they were provided with and that it was usually hot and to a good standard. They told us that they could choose what they wanted to eat and that if they did not like the main meal an alternative would be provided. We saw staff chatting and laughing with people as they assisted them to prepare for lunch. As people gathered for lunch they were encouraged to take a seat and those who required assistance were gently supported into their seat. People were then given a choice of drinks with their lunch.

People were offered a choice which was available in pictures if needed. People's dietary requirements were understood by the staff preparing and serving the food and the staff assisting people in the dining rooms or in their bedrooms. People's preferences were met by staff who gave individual attention to people who needed it.

Training consistently provided staff with the knowledge and skills to understand people's needs and deliver safe care. The provider had systems in place to ensure staff received regular training, could achieve recognised qualifications and were supported to improve their practice. Training was planned to enable staff to meet the needs of the people they supported and cared for. For example, staff received dementia awareness training and gained knowledge of other conditions from health and social care professionals visiting the service. Staff told us that the training was well planned and provided them with the skills to do their jobs well.

New staff inductions followed nationally recognised standards in social care. The training and induction provided to staff ensured that they were able to deliver care

Good

Is the service effective?

and support to people to appropriately. Staff were provided with regular one to one supervision meetings as well as staff meetings and annual appraisal. These were planned in advance by the registered manager and fully recorded. Training records confirmed staff had attended training courses after they had been requested in supervision meetings.

Staff had received training in relation to caring for people with behaviours that may cause harm to themselves or others. This often occurred when people living with dementia became frustrated or anxious, often without obvious cause. We observed that staff used the techniques they had learnt to keep people calm and prevent potentially harmful behaviours from developing. For example they used items that were familiar to someone to calm a person who had become distressed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the 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. Care plans for people who lacked capacity, showed that decisions had been made in their best interests. These decisions included do not attempt cardio pulmonary resuscitation (DNACPR) forms, and showed that relevant people, such as social and health care professionals and people's relatives had been involved.

The registered manager understood when an application should be made and how to submit them. Care plan records demonstrated DoLS applications had been made to the local authority supervisory body in line with agreed processes. This ensured that people were not unlawfully restricted.

Good

Is the service caring?

Our findings

People said, "I like it here and the staff here are very nice. I can look out of the window and they let me walk around. They (staff) speak when I meet them, they smile at me". "All the girls (staff) here look after me. I get breathless and I make myself walk. I know they are all waiting to help if I get into trouble and I know they do anything to help". Another person said, "I am very happy here. Staff are so kind and I never get the impression that it is because they have been told that, I feel that nothing is too much trouble for them and they really mean it".

Staff built good relationships with the people they cared for. Staff told us that as a team they promoted a non-discriminatory atmosphere and a belief that all people were valued. This resulted in people feeling comfortable, relaxed and 'at home'. We observed staff speaking to people and supporting them. This happened in a caring and thoughtful way. We observed that staff ensured a lively, jovial atmosphere. We saw staff listening to people, answering questions and taking an interest in what people were saying. Two staff who needed to move a person using a hoist put the person at ease by talking her through the process and confirming with her if it was okay. When speaking to people staff got down to eye level with the person and used proximity and non-verbal's (good eye contact, caring gestures, smiles and nods). People responded well to the quality of their engagement with staff.

People were encouraged to communicate their needs in their chosen style or where they could no longer communicate their needs verbally as their dementia became more progressive. For example, through facial expression and mood. Communication care plans described people's communication needs on a day to day basis. The care plans included a good level of information so that it would be clear to staff reading them how best to communicate with the people they were caring for. Reference was made to hearing / visual aids people had and the support they needed to use these. The notes for one person recorded that they needed to wear 'distance glasses' and that staff should remind them / support them to do so. Staff were heard to ask if the person wanted their glasses at one point during the morning. People asked for and were provided with pain relief to help them maintain their comfort and dignity.

Staff described the steps they took to preserve people's privacy and dignity in the service. We observed that staff knocked on people's doors before entering bedrooms to give care. People were able to state whether they preferred to be cared for by male or female staff and this was recorded in their care plans and respected by staff. People were able to personalise their rooms as they wished. They were able to choose the décor for their rooms and could bring personal items with them. People told us that their care plans were followed and they could say what they wanted staff to help them with.

Staff operated a key worker system. Each member of staff was key worker for three or four people. They took responsibility for ensuring that people for whom they were key worker had sufficient toiletries, clothes and other supplies and liaised with their families if necessary. This enabled people to build relationships and trust with familiar staff.

People had choices in relation to their care. Care plans covered people's preferences about personal care and personal hygiene needs. The care plans made reference to promoting independence and helping to maintain people's current levels of self-care skills in this area. For example, people had asked for their food to be cut up so that they could manage the meal themselves. Or encouraged to maintain their independence when walking but have staff nearby if they needed them. We observed staff followed people's requests. In the annex people had tea and coffee making facilities in their rooms as well as a microwave. This enabled then to remain independent. People or their representative had signed to agree their consent to the care being provided whenever possible.

Staff fully supported people's decisions about their end of life care. Records demonstrated that people's wishes in this area were discussed with relatives and the end of life care facilitator from the local hospice. An end of life facilitator from a hospice said, "I have found that staff have accepted residents choice if they wish to die in the home and go the extra mile to ensure they receive the best care they can provide."

People and their relatives told us they had been asked about their views and experiences of using the service. They were involved with developments and events within the service and they could influence decisions the provider had made. We found that the registered manager used a range of methods to collect feedback from people. There

Good

Is the service caring?

were residents and relatives meetings at which people had been kept updated about new developments in the service. For example, a new sensory room was being discussed. We found that the results of the surveys/ questionnaires were analysed by the provider. Information about people's comments and opinions of the service, plus the providers responses were made available to people and their relatives. In the last survey conducted in October 2015, people told the provider they were highly satisfied with how staff respected and involved them.

Information about people was kept securely in the office and the access was restricted to senior staff. When staff completed paperwork they kept this confidential.

Good

Is the service responsive?

Our findings

People were encouraged to discuss issues they may have about their care. People told us that if they needed to talk to staff or with the registered manager they were listened to. One person said, "I would not hesitate to complain to the management if I felt something was not right".

A health and social care professional said, "The activities co-ordinator is keen to focus on the needs of dementia patients which was refreshing to see, and I believe they were using Namaste for their end of life patients". (Namaste is a method of positively engaging with people living with dementia or who are receiving end of life care.)

People's needs had been fully assessed and care plans had been developed on an individual basis. Before people moved into the service an assessment of their needs had been completed to confirm the service was suited to the person's needs. Care planning happened as a priority when someone moved into the service. We saw a care plan that had been completed on the same day a person moved into the service.

'Critical care plans', were signposted in the first section of peoples care records. These included the areas of care such as; communication, falls, hygiene, eating and drinking, behaviour and toileting. The care plans were person centred, individualised, reflected people's assessed needs and included sufficient detail as to be clear to staff what was expected of them in relation to people's care. People and their families where appropriate, were involved in discussing and planning the care and support they received. We saw that assessments and care plans reflected people's needs and were well written.

The care people received was kept under review at least monthly so that it continued to meet their most up to date needs. People's life histories and likes and dislikes had been recorded in their care plans. This assisted staff with the planning of activities for people. Care was personalised and responsive to people's needs. Comments in care plans showed this process was on-going to help ensure people received the support they wanted. Family members were kept up to date with any changes to their relative's needs. Changes in people's needs were recorded and the care plans had been updated.

If people's needs could no longer be met at the service, the registered manager worked with the local care management team and continuing care team to enable people to move to nursing care or other more appropriate services.

The registered manager sought advice from health and social care professionals when people's needs changed. People were protected by staff who responded to emergencies appropriately. Several people told us that they had experienced prompt medical attention from the emergency services when they were ill. Records of multi-disciplinary team input had been documented in care plans for Speech and Language Therapist, Continence nurses and District (Community) Nurses. These gave guidance to staff in response to changes in people's health or treatment plans. There was continuity in the way people's health and wellbeing was managed.

Best practice guidance was being followed in relation to adaptions for people living with dementia. There were memory boxes and personalised pictures on or near peoples bedrooms so that they could identify their rooms. Also, toilet door frames and toilet seats were brightly coloured so that they could be seen easily.

Staff responded quickly to maintain people's health and wellbeing and worked to minimise the risk of people becoming isolated. Staff had arranged appointment's with GP's when people were unwell. One person said, "The staff always come to see how I am and if I am not well I can stay in bed and they call the Doctor. Staff come to chat to me too, so I read a lot and feel they are my friends, but they will phone my family if I feel lonely and one of my sisters will come immediately".

In response to people at risk of falling there were specific individual safe moving and handling plans to instruct staff. Technology like fall alarms was considered where appropriate to alert staff if someone fell, so that staff could respond quickly to provide assistance.

The activities people could get involved in were advertised within the service. Planned activities included visits from local faith groups, there were entertainers booked as well as opportunities to visit local parks. Each person's activity preferences and participation was recorded in an individualised activities book. On the day of the inspection the designated activity co-ordinator became unavailable at short notice, so we could not observe the planned

Good

Is the service responsive?

programme for that day. However, staff ensured that people could choose to participate in various activities such as listening music and singing. Staff sat with people individually to encourage their enjoyment of the activity and when this happened we observed people involved smiled and clapped to the music. Other people in the room joined in either singing or clapping to the beat. We could see from people's activity books that activities had been taking place. The activities people had chosen to do in their care plans were reflected in the records in the activity books.

There was a policy about dealing with complaints that the staff and registered manager followed. This ensured that complaints were responded to.

There were examples of how the registered manager and staff responded to complaints. There had been one complaint in the last twelve months. The complaint had been acknowledged, investigated and responded to in writing and had been resolved to the person's satisfaction. All people spoken with said they were happy to raise any concerns. The registered manager always tried to improve people's experiences of the service by asking for and responding to feedback.

Good

Is the service well-led?

Our findings

The manager was registered with CQC in August 2013. They had provided consistent leadership for the service since then. They were qualified and experienced in managing services for people living with dementia.

People said, "The (registered) manager manages staff and us in a very casual way which accounts for the happy atmosphere". Another person said, "The (registered) manager goes round every day and we know her and she knows all about us".

Staff felt supported by their colleagues and the registered manager. One said, "I love my job", another said, "This was probably the best care job I have ever done".

People's positive experiences of the service were underpinned by consistent improvement. The registered manager carried out regular audits of health and safety risks within the service and of the quality of the service provided. The registered manager told us that the provider listened to, considered and acted on requests made for additional resources. We saw examples of expenditure the provider had made in response to request for improvements. For example, the laundry room had been extended so that the management of dirty and clean laundry and infection control was effective.

General risk assessments affecting everybody in the service were prominently displayed to increase people's awareness of the steps taken to minimise risk. Service quality audits were planned in advance and recorded. The frequency of audits was based on the levels of risk. For example, daily management walk around audits had taken place to check for any immediate risk such as trip hazards or blocked exits. The audits were effective and covered every aspect of the service.

Managers from outside of the service came in to review the quality and performance of the service's staff. They checked that risk assessments, care plans and other systems in the service were reviewed and up to date. An independent pharmacist carried out audits of medicines. All of the areas of risk in the service were covered; staff told us they practiced fire evacuations. We could see that issues identified on audits were shared with the registered manager who recorded how and when they would make the improvement picked up by the auditor. For example, air conditioning had been installed in the medicines room to maintain the recommended storage temperature of medicines since the audit in August 2015. This had been signed as completed by the registered manager on their action plan which was re checked by the auditor at the next audit. This ensured that issues identified on audits were actioned and checked to improve service safety and quality.

The aims and objectives of the service were set out and the registered manager was able to follow these. For example, providing people living with dementia with care and support through a skilled and knowledgeable staff team. Staff received training and development to enable this to be achieved. The registered manager had a clear understanding of what the service could provide to people in the way of care and meeting their dementia needs. This was an important consideration and demonstrated the people were respected by the registered manager and provider. Where people needed to be referred to other care providers, for example if they needed nursing care, the registered manager supported this process.

People benefited from staff who felt valued by the provider. Staff were asked their views about the quality of the service. This included an annual staff survey, the results of which had been analysed and fed back to staff. The results of the last survey were consistent with what staff told us during the inspection. Staff described the culture and values of the service as being grounded in respect and on promoting people to retain what independence they could. Staff told us there was an emphasis on creating normality and a home from home for people who lived at Park View. Staff told us that team work and communication at Park View was excellent. They said that they were not worried about sharing any concerns that they might have about the care provided. They talked about person centred care and about shaping the service to people's individual needs.

Staff said that they could talk openly with the registered manager and that she made herself easily accessible to encourage them to do so. The registered manager kept the team informed about service developments through supervisions and team meetings. Staff said, "The manager was always ready to consider any suggestions which they might like to make".

Good

Is the service well-led?

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

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

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

Senior managers at head office were kept informed of issues that related to people's health and welfare and they checked to make sure that these issues were being addressed. There were systems in place to escalate serious complaints to the highest levels with the organisation so that they were dealt with to people's satisfaction.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The registered manager was not ensuring that at all times there were enough staff deployed to cover both the emergency and the routine work of the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 (1) (a) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The registered manager was not ensuring that they were obtaining information as specified in Schedule 3 when they recruited new staff.**