Sensation Care Ltd

Parklands Care Home

Inspection report

Station Road
Rawcliffe
Goole
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 2 October 2017 and was unannounced.

Parklands care home provides residential care for up to 30 older people and people who may have a dementia related condition. It is situated in the village of Rawcliffe, five miles from the town of Goole, in the East Riding of Yorkshire. There are various communal areas including lounges and dining rooms for people to use. People have access to outside gardens and seating areas, which are provided in secure settings. There is car parking for staff and visitors to the rear of the home.

There was a registered manager in post. 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 registered manager will be referred to as 'manager' throughout the report.

At the last inspection in May and July 2016 the overall rating for the service was Good. The rating for Responsive was Requires Improvement. This was because we found the provider did not have adequate systems and processes to record and respond to complaints. We made a recommendation for the provider to seek advice and guidance on the management of complaints. During this inspection we checked and found improvements had been implemented based on our recommendations with a clear process in place to record and respond to complaints.

Systems and processes were in place that helped keep people safe from harm and abuse. Care workers had completed safeguarding training and knew the signs of abuse to look out for and how to raise any concerns.

The provider ensured there were sufficient skilled and qualified care workers to meet people's individual needs and preferences. Recruitment checks were completed that helped the provider to make safer recruiting decisions and minimise the risk of unsuitable people working with vulnerable adults.

The service was working within the principles of the Mental Capacity Act 2005. Care workers understood their responsibilities under the MCA and were actively promoting people's independence. The manager and care workers had an understanding of Deprivation of Liberty Safeguards. They had made appropriate referrals to the relevant authorities to ensure people's rights were protected.

The provider was implementing measures to ensure consent to care and support was robustly recorded and were reviewing their policies and procedures for obtaining and recording consent.

People were supported with their health and wellbeing and had access to other health services when they needed to.

We received positive feedback about meal time arrangements at the home. The chef was aware of and catered for people's specific dietary requirements that were recorded in their care plans.

An activities coordinator ensured people were supported to enjoy a programme of activities that they could join in on their own or as part of a group. People were supported to ensure they did not become socially isolated.

Systems and processes were in place to ensure medicines were managed and administered safely as prescribed in line with best practice.

There were systems of audit in place to check, monitor and improve the quality of the service. We recommend the provider review their quality assurance policies and procedures to assure their effectiveness.

The manager understood their responsibilities as part of their registration with the CQC and had informed the CQC of significant events in a timely way. However, we found that notifications to the CQC for applications and outcomes of four DoLS that are required as part of their registration had not always been completed effectively. We recommend that the provider reviews their process for submitting all required notifications.

Everybody spoke highly of the manager staff team and the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Safe

People were protected from avoidable harm and abuse.

People received their medicines safely as prescribed.

Risk assessments provided staff with information to provide safe care and support.

Appropriate checks on care workers were completed to ensure they were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

The manager and staff understood their responsibilities in respect of the Mental Capacity Act 2005.

The provider was implementing measures to ensure consent to care and support was robustly recorded.

People had a varied diet and had access to other health professionals to maintain their health and wellbeing.

The environment within the home was comfortable, clean and homely.

Is the service caring?

Good

The service was caring.

People's individual care and support needs were understood by care workers, and people were encouraged to be as independent as possible.

People's end of life wishes and preferences were recorded where this had been agreed.

People's privacy and dignity was respected by staff who understood when to maintain confidentiality and when to share

any concerns.

Is the service responsive?

Good

The service was responsive.

The provider had information for people to follow to make a complaint and they were supported to do this if required. Any complaints were taken seriously and fully investigated.

People and their relatives were involved in planning their care and support.

People were supported to enjoy activities and interests of their choosing.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems and processes with associated action plans were used to demonstrate a commitment to continuous improvement. However, because of the concerns we found during our inspection we made a recommendation for the provider to review their quality assurance policies and procedures to assure their effectiveness.

Everybody spoke highly of the registered manager and the provider. Staff understood their roles and responsibilities and when to escalate any concerns.

The manager understood their responsibilities as part of their registration with the CQC.

Notifications to the CQC for applications and outcomes of DoLS had not always been completed effectively. We recommend that the provider reviews their process for submitting all required notifications.

Parklands 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 registered 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 2 October 2017 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and one expert 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. The experts by experience who assisted with this inspection had knowledge and experience relating to older people and those living with dementia.

Before the inspection, we looked at information we held about the service, which included notifications sent to us since the last inspection. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service.

Before the inspection we asked the registered provider to submit a provider information return (PIR) prior to the inspection and this was returned within the given timescale. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. As part of the inspection process we contacted the local authority who provided their feedback.

At this inspection we spoke with the manager, the administration officer, the chef and kitchen assistant, the laundry assistant, six care workers and a district nurse. We spoke with five people and eight relatives who were visiting people at the home.

We observed interactions between people, relatives and care workers in the communal areas and during mealtimes. We looked at how the provider managed and administered people's medicines and we observed a medication round.

We looked at all areas of the home, including bedrooms (with people's permission). We spent time in the

office looking at records associated with the running and management of the home. We looked at individual care records for three people who lived there and we looked at records on file for four care workers.

Good

Is the service safe?

Our findings

People we spoke with confirmed they felt safe living at the home and with the care workers who supported them. One person said, "I do like living here, it's a safe place to be." All relatives spoken with were positive about the standard of care and safe treatment provided by the service.

Care workers understood and had access to appropriate safeguarding policies and procedures. They were able to discuss the types of abuse to look out for and how to raise any concerns. The manager showed us a safeguarding file where concerns were recorded. The file included a 'root cause analysis' with actions that were evaluated to help keep people safe. The provider followed local safeguarding protocols and the manager discussed when they would escalate concerns for further investigation by the local authority safeguarding team. This meant systems and processes were in place to help keep people safe from avoidable harm and abuse.

Risk assessments had been completed for any areas that were considered to be of concern. People had individual risk assessments that included skin integrity, mobility, moving and handling and falls recorded in their care plans. Other assessments of risks for the use of equipment for example, bed rails and wheelchairs had been completed and this ensured equipment was safe for people to use. Care plans included associated support plans and other records that ensured care and support was provided safely and without undue restrictions in place. Risk assessments were evaluated at least monthly to ensure they remained relevant and up to date.

The provider completed checks that ensured the home and environment was safe for everybody. Service certificates were up to date and provided assurances that the lift, premises, and equipment were being maintained in a safe condition. Checks were completed to ensure beds and associated equipment, for example, bed rails were safe for people to use. Certification that checks had been completed to prevent Legionella was made available. Legionella is water borne virus that can cause lung diseases similar to pneumonia.

We observed that care workers ensured people had unrestricted access to the communal areas both inside and outside the home.
Other areas such as the kitchen, medication room and the store rooms were kept locked, to keep people safe and avoid any risk of harm to them. There was a central secure cupboard used for the storage and control of substances hazardous to health (COSHH). Risk assessments had been completed on these materials. Some store rooms were disorganised and included storage for items that required disposal, and cleaning chemicals that required moving to safe storage. These areas were locked and the manager dealt with these concerns proactively during the inspection.

There were current maintenance certificates in place for the fire alarm system, fire extinguishers, portable electrical appliances, gas safety and the electrical installation. There was a fire risk assessment in place. We saw the provider used a removable securing bolt to prevent two fire exit doors opening during fire alarm tests. One bolt was in place during our inspection. The manager told us "They [bolts] have always been

used, even prior to my employment to prevent people wondering out of fire exits when the alarm was checked." Previous fire inspections and risk assessments had failed to identify or include the use of the bolts. During our inspection the manager sought guidance from the local fire service regarding the use of the bolts, which they removed along with the fixings. This ensured all fire exits were always free from obstruction should there be an emergency evacuation due to a fire.

Records confirmed weekly fire evacuation drills were completed. There was a contingency plan in place that included advice for care workers on how to deal with emergency situations. In addition to this, each person had a personal emergency evacuation plan (PEEP) in place. A PEEP is a record of the support each person would require to leave the premises in an emergency, including any equipment that would be needed and how many care workers would be required to assist.

Care plans included an assessment to ensure people were supported with their medicines where this was required. Where people were able to take their own medicines or required just a prompt, care workers were aware and encouraged people's independence. Care workers involved with medicines had received up to date training. The manager had implemented spot checks that ensured care workers were competent in this activity.

We checked the policies and procedures in place for medicines management and we observed people receiving their medicines over the lunch time period. There was a designated care worker who had responsibility for medicines. We observed they did not wear a red tabard whilst dispensing medication to avoid being disturbed. In order to follow best practice the manager told us they had purchased replacement tabards for care workers to wear when administering people's medicines. The care worker checked the Medication Administration Record (MAR), administered the medicine and waited until the person had taken the medicine, assisting where necessary before completing the MAR.

There was a system and process in place for the ordering, storage, handling and disposal of medicines and this was in line with best practice. Protocols for administering medicines that were prescribed, 'as and when required' for people were in place. Records were up to date and audits were completed to maintain safe practice. Controlled drugs that required special arrangements were administered, recorded and stored safely. This meant people received their medicines safely as prescribed.

During our inspection there were sufficient numbers of suitable care workers on duty to meet people's individual needs. The manager told us they evaluated the rotas daily to ensure the service had the required skilled mix of care workers. They said, "When we have activities where care workers are involved for example, bingo, we plan for those events and rota additional staff. We do sometimes use agency. Agency staff are 'familiar faces' who work with us a lot; the agency sends us 'staff profiles' so we know they are suitable for the role."

The provider had completed pre-employment checks that helped to ensure care workers were of suitable character to work with vulnerable people. This included checks with previous employers, where we saw references had been obtained and recorded, and checks with the Disclosure and Barring Service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands and can help employers make safer recruitment decisions. Care workers had completed application forms, interviews and health checks that ensured they were fit and healthy and understood the expectations of their role.

The manager had a policy and procedure in place to manage infection control around the home. The manager completed monthly infection prevention and control audits that included a monitoring form for

care workers and cleaners to record and sign where checks had been completed. Training in this area was completed and recorded for all staff as part of their induction programme and refreshed every three years. Our observations confirmed high levels of cleanliness and infection control around the home with no unpleasant odours.

Good

Is the service effective?

Our findings

We checked to see if the provider was following legislation under the Mental Capacity Act 2005 (MCA). The 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).

Where people had been deemed as not having capacity by the provider, applications had been submitted to the local authority for further assessment and approval of a DoLS. Where an assessment for a DoLS had been completed, we found best interest decisions had been made and recorded.

We found that where people had capacity to agree and sign their consent or where they had an appointed individual to sign to provide consent on the person's behalf, this had not always been clearly recorded. For example a person's care plan identified the person had a Lasting Power of Attorney (LPOA) to allow a nominated individual to make decisions on behalf of the person for their health and welfare. The care plan included a psychological assessment which recorded that family involvement may be required. However, a form to record their involvement and that of the LPOA in their care planning had not been completed.

Another care plan included an assessment and authorised DoLS for a person. The care plan detailed involvement from an advocate to ensure the person had a voice and was able to contribute to their care and support planning. The advocate attended every six weeks. However, there was no record of their input or involvement in the support provided.

The manager had awareness of, and was responsive to our concerns. The manager told us, "We are updating care plans and we will input an 'assessment of capacity form' that includes provision for the person or their nominated representative to record their consent to the care and support provided." A copy of the form was provided. This meant the provider had implemented measures to ensure they always recorded consent and were following requirements of legislation and guidance from the MCA.

We looked at training records for care workers but found completion of specific MCA training had not been recorded. The manager told us care workers completed a work book that included this information and that it was also covered in the vocational qualifications completed by some care workers. The manager also showed us training in the MCA that was planned for implementation in October 2017. Despite the lack of recorded training, care workers who we spoke with were able to demonstrate an understanding of the MCA. Comments included, "Even if someone has a DoLS in place, I would still offer them choices about day to day decisions such as what to eat or wear." "I would always assume someone had capacity and would always ask them if they understood and agreed to our suggestions to provide care and support." "I would always give people choices and help them to make their own decisions."

All interactions between care workers and people were observed to be positive and cheerful. It was clear care workers had the required skills and knowledge to carry out their roles and responsibilities. We observed a particularly skilled and effective care worker use reassuring language and support to calm one person who showed signs of agitation. The care worker told us, "We have all received good training and a lot of the work we do to support people comes quite naturally. There is information and support available for us to provide people with good quality care to meet their needs." During our inspection we saw two care workers moving two people using operating equipment. They completed the process safely and with confidence, whilst engaging them in reassuring conversation.

The provider ensured all care workers received an induction to their role, the service provided and the people who lived there. This included an oversight of policies and procedures, housekeeping and an introduction to peoples' records. The manager told us all new employees who had not completed previous vocational care training were required to complete the care certificate as part of their induction process. Records confirmed this. The care certificate is a set of basic standards in providing care and support for care workers to adhere to in their daily role.

The manager showed us a training matrix which recorded training completed by care workers and other staff. This included scheduled refresher training that ensured all employees were kept up to date with the latest best practice and new ways of working. A care worker confirmed, "We receive good training that keeps us up to date and we also receive training appropriate to people's individual needs." We saw training in areas the provided considered mandatory was completed. This included safeguarding, moving and handling, medicines, fire safety, health and safety and infection control. Other training to meet people's individual needs included dementia awareness, managing potential challenging behaviour and pressure sore awareness.

Care workers told us they felt supported and were encouraged to develop their skills. We saw care workers received regular supervisions that included a self-assessment. A care worker said, "We fill out the assessment and provide feedback which is discussed along with any attendance, training, workloads and concerns we may have during the supervisions; it is a good process and it's not just one sided." The manager showed us how supervision and appraisals were planned across the year. They told us, "We try and complete at least two to three supervisions and one annual appraisal a year and schedule other meetings where we need to record a discussion."

People were supported to have sufficient to eat and drink and were supported with a balanced diet. Any dietary needs were recorded and catered for. Where required records included input from a dietician. The chef confirmed they acted on this information. Both pictorial and standard menus were displayed on walls in the dining room showing a good healthy variety of food. People told us they were happy with the meal time arrangements. Comments included, "The chef is very good." "Sometimes there is too much food; but it is always enjoyable." "Meal times are great and we have drinks and snacks throughout the day."

We observed lunchtime in the dining room where most people choose to eat. Care workers provided people with individual assistance where this was required. Other people were served in their rooms or lounges according to choice or individual capacity. The meals looked appetising, nutritious and well cooked. Where people did not like one of the two main courses provided, individual food was prepared.

People were supported to maintain their health and wellbeing. People confirmed they had access to their GP when required and we saw care plans recorded involvement with other health professionals such as psychiatrists, chiropodists, and dieticians. A visiting district nurse who had good knowledge of the home, confirmed they judged the home to provide good first line health care and liaised effectively with the

Community Health Service. They said, "The provider does not delay in contacting us with any concerns. In 15 years of visiting the home as a district nurse there has been no serious untoward incidents." The manager and District Nurse both confirmed that liaison with local GPs was equally effective.

The three lounge spaces allowed people to enjoy each other's company or be on their own, according to their choice. The large, air-conditioned conservatory was enjoyed the most by people. It was well lit and ventilated with good views of movements on the adjacent road and pavements. The premises were reasonably decorated but some areas were in need of decorative attention. People's rooms were of sufficient size although some rooms had low lighting levels. Individual rooms were decorated with people's personal possessions and items of furniture which made them feel homely. All rooms had wash basins. The one general use bathroom on each floor of 15 rooms was acknowledged to be basic and there were plans to double this provision.

We observed a resident safely using a wheelchair unaided but noticed that the limited width of door openings presented risk of the person damaging their fingers. The manager was aware of the short falls. They discussed how they had recently decorated the dining room and were having discussions with the provider regarding further refurbishment plans. This included further decoration, adaption of the entrance, increased bathing provision and widening of some door ways.

Good

Is the service caring?

Our findings

Care workers were observed to have a positive and pleasant attitude towards people and provided care and support safely with empathy and compassion. It was clear that care workers understood people's individual needs and preferences and that people knew the care workers and manager who worked at the home. One person told us, "They [care workers] are all lovely, I don't know where I would be without them." A relative said, "The care workers here are responsive and caring. The manager is equally good. I have no concerns and I would be happy for any of my relatives to reside here."

People assured us that care workers had meaningful relationship with them, that they cared about them and understood their needs. They told us they helped them settle in the home and have a fulfilled life. One person said, "I have been here for a lot of years and have no concerns about my treatment; I have a bit of a laugh with the care workers who are like family to me."

Care plans recorded people's preferred name and we saw that these were used by care workers. We observed that care workers respected privacy by knocking on doors and asking if they could enter the room. Care plans recorded people's bathing preferences and they were able to have the choice of a bath, shower or just a wash. One care plan recorded, "[Person] likes to have a deep bath that covers their shoulders so they can have a relaxing soak."

A care worker told us how they protected people's dignity by closing curtains and making sure people knew they were using the bathroom so they were not disturbed. Another care worker said, "Where people need assistance with bathing we cover them with a towel to protect their modesty and encourage them to do what they can for themselves. We have to be patient but it's important people enjoy the experience; all part of the job."

Care workers routinely engaged people in conversation asking them how they were, if they needed anything and were responsive to any questions and feedback, taking their time to ensure people were not left without support.

We asked people how care workers communicated with them and if they received information in a way that was easy to understand. They told us, "I have a hearing aid, they know to make sure it is switched on and that I can hear them." "They are a good at asking me if I need anything, I like to spend time in my own room and they pass by and check I am okay." Care plans included information to help care workers communicate with people. One care plan recorded, "I am quietly spoken and require patience and time to respond. I like to be asked what I want and provided with choices." Care workers were aware of people who had hearing and sight problems and encouraged them to wear their spectacles and hearing aids.

The provider ensured people's personal beliefs were supported. People we spoke with confirmed they could take part in spiritual activities if they so wished. One person said that they loved singing. Another person told us a local vicar used to attended but had not visited recently. One relative said, "The provider does listen to suggestions and are keen to deliver the best care. We are very impressed with the staff response."

Care workers recognised the need to maintain people's confidentiality. A care worker said, "I would only discuss anything I heard with the relevant people on a 'need to know' basis in particular if it was a safeguarding concern." We saw that records and electronic information about people who lived at the home and staff was stored securely and only those individuals who needed to, had access.

The provider told us on the PIR, 'We are looking at trying to keep people out of hospital at the end of their life if that's what's they wish, and enabling them to stay at the home with the assistance of district nurses.' The manager told us this was a sensitive subject to discuss with people and their relatives but that they were pro-active in recording people's wishes. A district nurse commented: "The Home is very good at seeking my advice for a resident on an end-of-life pathway. They are treating them with dignity, respect and ensue they remain pain free."

Care workers confirmed they had completed training in end of life care. Where people had chosen to, their end of life care wishes were documented in their care plans and kept under review. Do not attempt cardio-pulmonary resuscitation (DNACPR) decisions were recorded where appropriate.

Residents told us and our observations confirmed people were able to receive visitors without any restrictions. Visitors said that they were able to visit any time. A relative confirmed, "I'm here seven days a week, I can visit at any time; and I do."

Good

Is the service responsive?

Our findings

During our previous inspection in May and July 2016 we found the recording of complaints was inconsistent. We recommended the service sought advice and guidance on the management of complaints.

At this inspection care workers discussed with us how they supported people to raise a concern or complaint. Comments included, "We can often deal with any daily concerns as they happen but if someone was unhappy we would assist them to follow the complaints process." "We always know when people are able to tell us they are unhappy but where they are unable to communicate as well, we can usually tell by their body language or a mood change. It is about understanding people. We have good support systems and people would always be supported to raise any concerns." The provider had a complaints policy and along with any compliments received, information was actioned and logged. Recording of complaints had improved and included a monthly summary. This highlighted any completed and ongoing actions. The monthly summary had oversight by the provider to ensure responses and actions as a result, were effectively completed and we saw this was signed.

We observed care workers were responsive to people's individual needs. People had access to a call bell and our observations confirmed they did not have to wait long after sounding the bell to be attended to.

The provider had developed a personalised approach to responding to people's needs. Before people moved into the home their needs were assessed to ensure the service was suitable for them. Following this initial assessment, individual care plans were developed that provided guidance about how each person would like to receive their care and support. This included their preferred routines of care and how they communicated their needs.

Care workers confirmed care plans were up to date and used to ensure they could respond to people's individual needs and preferences. Comments included, "The care plans include good background information about the individual." "If we are unsure or need guidance we can always access the care plan; they include up to date information."

Care plans included a snap shot of a person's life. This provided members of staff with information about their family and what they enjoyed doing during the day. There were records of what relatives had said they admired about the individual and what the person said was important to them. A relative told us, "We are involved in my husband's care planning, including meetings with the therapists. His dietary needs are noted carefully and he has a personalised menu." Each person's care plan had a one-page personal profile that included their photograph, details of their next of kin, other health professionals involved in their care and details of any religious beliefs.

Routines for waking, and for retiring to bed ensured people were supported by the required number of care workers according to their needs and ability. Other records included, washing and dressing, hair care, foot care, sight, tissue viability, falls history and continence. Information recorded the type of support required and how much the person could complete on their own. A care worker said, "We always encourage and

support people to be independent and complete as much for themselves as they can do."

Records showed care plans were evaluated monthly for their effectiveness. Where no change was required this was noted. Where people's needs had changed the provider had amended the information. For example, we saw where a person was at risk of developing pressure sores, the provider had sought guidance from the district nurse and had updated the person's records to reflect the guidance provided and this was evaluated.

Other daily records were completed to record when people had been repositioned where they remained in their bed. However, we found that this information had not always been completed. We spoke to the manager who understood the importance of maintaining accurate records. They said, "We check record keeping as part of the daily walk round, sometimes care workers will forget to record something as they move around the home, completing tasks. Our checks should identify any omissions and we would speak with the care worker to ensure the task had been completed and the records updated." The manager immediately investigated the omissions we noted.

Information was also recorded that ensured people's abilities, wishes and preferences were recorded for daily activities. The provider employed an activities co-ordinator and there was evidence of a varied programme that included good participation by relatives, care workers and on occasion their children. Activities at the home included crafts, jigsaws, dominoes, film night, hair dressing, hand massage, carpet golf, and a summer fayre. Recent highlights discussed by people included an outside visit to a tea dance and a classic and wartime songs evening with visiting singers.

Relatives discussed how the provider had responded to their loved ones individual needs. They said, "The staff try hard with activities; some residents do not appear interested but we have found there has been a significant improvement in [person's name] social interaction since coming here." "[Person's name] had a stroke. We visit every day and we see how well they are cared for. They are visited by a stroke nurse and a physio once per week and the carers continue their exercises at other times. [Person's name] mood is quite good considering they were a very active person before the stroke."

The manager told us and relatives confirmed that a significant number of people were taken on short trips away from the home by family members. In the home we observed good examples of care workers taking the time to engage one-to-one with people to discuss their day and ensure they were contented. Communal areas and corridors included displays, and pictures of times gone by that stimulated those people living with dementia into conversation. The manager told us that as part of the planned refurbishment they intended to expand on this area and discussed other themes that would stimulate the experiences of people who lived at the home.

People in the home were appropriately dressed and were supported to maintain good hygiene. The home had an in-house laundry service that was staffed by a dedicated assistant. Care workers discussed how they spent time providing people with hand massages and nail manicures and a visiting chiropody service was equally popular. The provider had a hairdressing salon on the first floor. The manager told us the intention was to refurbish and move this downstairs to the ground floor. People confirmed they were aware of this facility and it was clear it was well used. One person commented, "I look forward to visiting the hair dresser; I like the whole experience of having my hair looked after."

Care plans included a 'resident transfer' form. The form recorded the reason for the transfer, personal details, any health and medical concerns, degree of dependency and was used to ensure the person received continuing health care and support should they be admitted to a hospital. The provider also had a

'return from hospital' form that was used to check and record the person's move back home and ensured any changes for example, with their medication were updated in their care records.

Requires Improvement

Is the service well-led?

Our findings

We were supported during our inspection by a manager who was registered with the CQC. The manager understood their legal obligations as part of their registration. Registered providers must notify us about certain changes, events and incidents that affect their service or the people who use it. We checked our records and found notifications had been submitted. However, we found four notifications for submission and outcome of DoLS had not been sent to the CQC. The manager confirmed this was an oversight and submitted these in retrospect.

We recommend that the provider reviews their process for submitting all required notifications.

The provider completed quality assurance checks that included weekly medication audits, audits on equipment, a kitchen audit, (that including a monthly dining observation with associated actions completed) and an initial audit for people who moved into the home to ensure appropriate paperwork was in place. These audits ensured the service level was maintained and improvements made where necessary.

Other quality checks included an annual audit to review and maintain infection control, monthly care plan audits and daily checks around the home. However, we found that although these checks were in place they were not always effective due to the concerns we found. For example, daily positioning charts had not always been robustly completed and audits had failed to check all areas of the home. This included locked cupboards and rooms, that we found to be disorganised and included storage for items that required disposal, and cleaning chemicals that required moving to safe storage. Fire checks had failed to ensure all fire exits were always clear of obstruction. The manager had awareness of, and was responsive to all the concerns we raised during the inspection process and was keen to identify ways in which to improve the service. Corrective actions were implemented by the provider during and immediately after our inspection to address all of the concerns we found.

We recommend that the provider review their quality assurance policies and procedure to include additional checks that will prevent further re-occurrence of the concerns we identified during this inspection.

Everybody we spoke with told us they were happy with the management in place and found them to be open, approachable and transparent. Staff in all areas of the service expressed confidence in the manager's leadership and told us they believed the culture of the service was appropriately focused on people's care, safety and quality of experience. Comments from care workers included, "The manager is approachable and responsive. They are proactive and have good ideas for improving the service". "I enjoy the care industry. Everyone gets on well together." "I like working here and have been here for six years; the manager is responsive and open to discussing problems. They listen and understand." "The manager offers me flexibility about my work hours and ensures that we are all up to date with mandatory training. Both the manager and senior carers are supportive of training and encouraging me to progress."

Relatives we spoke with told us they were happy about the service provided and the accountability of the

staff team. One relative said, "I chose this home from several others which I had checked out with friends and the CQC reports. This was the best for staff friendliness, size of room, location and good reports of the service. The staff and manager are very approachable."

There was a clear staffing structure at the home and everybody understood their roles and responsibilities and when to escalate any concerns. The provider ensured information was shared through the home and service with everybody involved. Staff meetings with care workers, managers, domestic staff, kitchen staff and senior care workers were held and provided an opportunity for open dialogue and information sharing. The manager told us they aimed to have staff meetings at least quarterly with heads of departments and full meetings on a monthly basis.

The manager showed us a series of satisfaction surveys for people, family members and other stakeholders. Whilst the range of feedback sheets was good there were relatively few comments for improvement. The manager was responsive to our suggestions that the feedback sheets be modified to invite graded answers and explanatory comment rather than just a yes/no response. The manager said, "The suggested changes will provide an opportunity to identify any areas for improvement and will clarify what is working and what is not."

The manager told us they kept up to date with legislative changes and best practice working. They told us they subscribed to emails from the CQC and Skills for Care. The provider had formed good working links that included the local authority safeguarding teams, GP's, district nurses and other health professionals. These links ensured people had access to care and treatment to meet all of their needs when this was required.