Parkview Residential Home

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Parkview is registered to provide accommodation for 22 older people who require support and personal care.

This unannounced inspection was carried out on 22 June and 6 July 2016. At the last inspection on 12 June 2014 we found the provider met the regulations we looked at.

At the time of the inspection there were 22 people using the service.

A registered manager was in place and they were present on the days of the 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.'

Environmental risk assessments had not been carried out. There was an infection control risk due to the layout of the laundry room and its facilities. Areas of the home were in need of cleaning, maintenance or redecoration. There were offensive odours in some areas of the home. There was a lack of available communal toilets on the ground floor.

People were very happy with the care and support they received. They lived in a homely environment and were comfortable and relaxed. People described the good relationships they had developed with staff. Two people said, "The staff are good here … I can't grumble … we have a joke and a laugh but they are always on the ball" and "I am happy here because the staff make me happy."

Staff were enthusiastic and motivated in their jobs. The felt supported by the registered manager and had been recruited safely. They received training to do their jobs properly and were all very experienced in care. Several staff had worked at the home for several years. There were sufficient numbers of staff on duty at all times.

People said staff were kind and caring. Staff were compassionate towards people and ensured people's privacy and dignity was respected at all times. Staff treated people with respect and knew people well. People had opportunities to participate in a range of different social activities both inside and outside of the home. One person said, "If I was the Queen of England they couldn't look after me any better …"

Staff were aware of issues relating to safeguarding, and could describe the action to take should they have any concerns or should concerns be reported to them. Plans were in place to minimise identified risks. People's medicines were managed and stored appropriately.

People had a plan of care in place and any assessments of individual risk identified. People were supported

to maintain good health. They had access to healthcare services. People liked the food served, although they would like more choice over the variety of meals offered.

The provider had not always followed the processes required within the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Best interest decisions had not involved the people required.

People and their relatives knew how to make a complaint and would be listened to.

There was an open culture within the service. People were relaxed with the registered manager who knew people well. Staff spoke highly of the registered manager and two said, "No door is closed here …. (registered manager) works the floor so she knows what it's like" and "(registered manager) is brilliant … absolutely fantastic …"

The provider did not seek regular formal feedback about the quality of the care and support provided. Some systems were not in place to regularly monitor the delivery of the care. Records required for the running of the service were not always held.

We found three breaches of regulation and made one recommendation. You can see what action we told the provider to take at the back 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

Some aspects of the service were safe.

People were not protected from avoidable harm from the environment or infection control risks.

Some areas of the building required redecoration, cleaning and maintenance.

There were appropriate safeguards in place to help protect people using the service from abuse.

Sufficient numbers of suitably qualified staff were employed to keep people safe and meet their needs. Recruitment practices protected people from unsuitable staff.

Medicines were managed safely and people were supported to take their medicines as prescribed.

Is the service effective?

Requires Improvement

One aspect of the service was not effective.

The correct processes were not being followed regarding the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards. Best Interest Decisions had not been made with the appropriate people involved.

The staff team were trained to meet people's specific needs. Staff were supported with on-going relevant training. Regular supervision had been re-established.

People received the support they needed to maintain good health and wellbeing.

People received food they were happy with but would like to be offered more choice.

Is the service caring?

Good

The service was caring.

People were happy with the support they received from staff and felt well cared for. Positive relationships had developed between people using the service and the staff team.

Staff promoted peoples' independence in a supportive and helpful way. Staff demonstrated a caring attitude towards people and they understood people and their individual needs and preferences well.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Good

The service was responsive.

People received care and support as and when they needed it, which was line with their planned care, although some care plans lacked detail about personal histories.

People had access to activities of their choice on a daily basis. They were supported to maintain links with the local community.

People knew how to raise concerns or complaints should they need to.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

Systems were not in place to routinely monitor the quality of the service.

Regular feedback from people, their families and professionals was not sought.

Records required for the running of the service were not always kept.

The registered manager ensured an open and positive culture had been developed. People and staff felt listened to.

Staff were motivated, enthusiastic and supported.

Accidents and incidents were monitored by the registered manager to ensure any trends were identified and acted upon.

Parkview Residential Home

Detailed findings

Background to this inspection

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

We visited the service on 22 June and 6 July 2016. The inspection was unannounced and was carried out by one inspector.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed other information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law.

During this inspection we met each person at the service. We spoke at length with 12 of them to gain their views and experiences of the service. We also spoke with the provider, registered manager, six care staff, the housekeeper, four relatives, one friend and a visiting health care professional. We spent time observing the interactions between people who used the service and staff. We looked at three people's care records, three staff recruitment records, staff training and supervision records, medicines records, staffing rotas and records which related to how the provider monitored the quality of the service.

Following the inspection we contacted a further four health care professionals and received one response back. We discussed our findings of this inspection with the Environmental Health Agency.

The provider notified us they had contacted the local authority Quality Assurance Improvement Team (QAIT) for advice and guidance after the inspection. A visit to the service was planned by the QAIT on 7 September 2016.

Requires Improvement

Is the service safe?

Our findings

We found areas of concern which posed a risk to effective infection control and prevention, particularly in the laundry room. The laundry room was not well laid out due to the position of the washing machine and tumble driers. Clean and dirty laundry went through the same entrance, which increased cross infection risks. There were no defined areas to keep clean and soiled/dirty laundry apart; care staff took dirty laundry into the laundry room via the staff room. This was wrapped in a towel. Care staff had to pass the clean laundry area to get to the dirty laundry area to put soiled washing in the washing machine. The service did not regularly use the recommended disposable red bags for contaminated laundry; this was brought into the laundry in the same way as all laundry. This meant there was an increased risk of cross infection and contamination of clean laundry.

The laundry room was untidy, unorganised and unclean. Staff were unable to wash their hands in the double sink as this was full of handyman tools and equipment, such as vases. There was no hand wash or disposable towels available. This sink had not been used for some time and was dirty. There was another sink in a room off the laundry where staff could wash their hands. However, staff could not access this room as it was also used a storage area. The laundry room was cluttered and very dusty particularly behind the washing machines and tumble driers.

There was no dedicated laundry person. Care staff did this as part of their roles. The service did not refer to the guidance from the Department of Health: Infection Prevention and Control in Care Homes. We discussed the infection control risk with the registered manager and provider. The provider explained the poor layout of the laundry was not helpful or appropriate. They both agreed to take action to address this and reduce the infection control risk to a minimum. Following the inspection, the Care Quality Commission contacted the local Environmental Health Agency and discussed our findings.

Environmental risk assessments had not been regularly carried out which meant people might be at risk from their surroundings. For example, there was an area of carpet in the downstairs corridor that posed a risk. Lighting was also dim in this corridor which posted a risk for people with poor eyesight. Equipment, such as wheelchairs were also stored in the corridor which made it difficult for people to manoeuvre past. However, no accidents or injuries had been sustained to people due to this. The registered manager confirmed these would be addressed immediately and the lighting and equipment had been addressed on our second day. The carpet was planned to be repaired imminently but had been made safe.

Not all areas of the service were found to be clean and hygienic. Four people's bedrooms had an offensive odour and we saw stains on carpets. Whilst the majority of people's bedrooms looked tidy and clean, some communal areas were not clean. We spoke with the housekeeper who worked five hours on a Monday, four hours Tuesday to Thursday and four hours on a Saturday. They said they only had time to "surface clean" the private and communal areas. No deep cleaning took place, such as the removing and cleaning behind wardrobes or the taking down and washing of curtains. They cleaned a carpet if needed but routine carpet cleaning did not take place. Care staff cleaned carpets as part of their duties if they required it. They were also assisted by the maintenance person if needed. However, the cleaning was ad hoc and not organised.

The registered manager explained the four carpets in people's bedrooms were due to be replaced shortly as these had already been purchased.

There were assorted types of air fresheners in the home, both in communal areas and in bedrooms. This was to mask any offensive smells.

All care staff said there were not enough housekeeping hours at the home to keep the premises properly clean. The registered manager had also highlighted this and had discussed housekeeping hours with the provider.

Two previous toilets on the ground floor had been made into a wet room and one toilet. This was sited adjacent to the dining room and lounge area. This meant there was only one communal toilet for 22 people currently living at the home. Whilst this had made an accessible shower for everyone to use, three people and all staff said one toilet was a problem at certain times of the day. Each person had an en-suite toilet in their bedroom, but bedrooms were too far away for them to use at times. Therefore, they regularly used the communal toilet. The provider and registered manager were aware of this and were in the process of looking at changing the layout of the ground floor and removing an office to install a second toilet. One person said, "It's the biggest bug bear here … only one toilet … it's definitely a problem when they are lining up in wheelchairs."

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were areas of the home which required updating and decorating. For example, old non-working strip lights in one person's bedroom and wallpaper which needed updating in corridors. No programme of continued maintenance or redecoration was in place. Some areas of the home were bright and modern. They had been recently updated, such as the dining room and lounge areas. These were very comfortable and nice places to sit. No programme of continued maintenance or redecoration was in place.

People felt safe living at the service. Two people said, "Everything is fine here, it's OK I'm safe …. and I'm able to just get on with life" and "Do I feel safe? Yes very much so." Two visitors said, "It is safe here generally" and "People are safe here. I go in a lot of care homes and it's safe here … I visit a lot."

Individual risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. Where identified areas showed the potential to cause harm, there were clear actions for staff in order to effectively manage the risks. For example, one person had been highlighted as at risk of skin damage due to lack of personal care. Staff were aware of the actions to take to reduce harm. People's risk assessments were reviewed monthly or sooner if required.

People were kept safe from the risk of emergencies in the home. Personal Emergency Evacuation Plans (PEEP's) were in place. These informed staff and the emergency services about the level of support each person needed in the event of an emergency requiring any evacuation of the building.

Appropriate arrangements were in place in relation to the management of people's medicines. There were safe medication administration systems in place. People received their medicines as prescribed and from trained staff. Medicines were stored safely in the medicines trolley which was kept secure. Some medicines were also kept separately in a locked cupboard in the staff room. Medicines were stored at the recommended temperatures. Medication administration records (MAR) showed when people had received

their prescribed medicines at the right times. The use of medicines, such as prescribed creams, was recorded. Creams with a limited life once opened had been dated to ensure they were used effectively and body maps were used to direct staff where to put the creams. The service had received an inspection from the local dispensing pharmacist on 5 May 2016 with some recommendations made. These had all been addressed and resolved.

People were supported by sufficient numbers of staff to meet their needs. Care staff knew people's individual needs very well and described how they met them. People said there was always staff available to support them with their daily care needs and activities. People confirmed staff responded quickly. Their comments included, "Someone always comes when I need them" and "I am definitely well looked after … they staff look after you … they are always there." A health care professional said there was always enough staff on duty and visible in the home and "There is always someone in the lounge" (referring to care staff). People were looked after by a static and experienced staff team. Some care staff had worked at the service for many years. The newest three care workers to join Parkview had all brought skills and knowledge from previous care services.

Staffing levels ensured the correct numbers of staff were on duty to meet people's needs. The service was fully staffed and permanent staff covered any absences from sickness or annual leave. No agency staff were used. The registered manager also worked hands-on shifts. However, they had been required to cover higher shortfalls in staff than normal recently. They said this had impacted on their management time.

People were always accompanied to hospital and GP appointments by either the registered manager or care staff. During the inspection staff had time to support people in an unhurried manner and spent time with them.

Staff had a good knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. The provider had policies and procedures in place to help safeguard people from abuse and neglect. Staff had received safeguarding training. They were able to describe how they would report concerns both internally or externally should they identify possible abuse. Staff said they were confident the registered manager would take any allegations seriously and ensure they were dealt with. Staff comments included, "I would report it to the registered manager and if necessary go to the Care Quality Commission or the local authority", "I would report any bad practice to the registered manager or the provider and I am confident they would act on it or I would take if further" and "I wouldn't hesitate to report it immediately and I would report to the senior on duty or higher." There had been no safeguarding issues reported in the last twelve months.

The provider managed recruitment safely to protect people from unsuitable staff. Recruitment files contained completed application forms, interview records and background checks. Gaps in employment history were discussed. References were requested and checks were made with the Disclosure and Barring Service (DBS). The DBS holds information about people who may be barred from working with vulnerable people. DBS checks help employers make safer recruitment decisions.

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 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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

People's liberty was restricted as much as possible for their safety and well-being. The registered manager had submitted four applications to the local authority DoLS team to deprive people of their liberties. None of these had yet been authorised. Whilst these applications had been submitted to the local authority, a formal Mental Capacity Assessment had not been undertaken. The registered manager said two people were unable to give consent to care. Therefore the legal process to make formal decisions, made in the person's best interests, had not been followed. This had not involved all the necessary people required, such as relatives and professionals. The registered manager was unsure which people had Legal Power of Attorney's in place. Following the inspection, the registered manager contacted the local authority Quality Assurance Improvement Team for advice and guidance on Mental Capacity Assessments. MCA training had been booked initially for senior staff and then for the remaining staff who had not yet undertaken it.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff who had access to a range of training to develop their skills and knowledge. This included face to face teaching sessions from various professionals and on-line training. Due to a technical issue with the provider's computer system, a complete record of staff training was not available. Some staff training records were held in individual files; but the registered manager said these were not a complete record and some of the most recent information was not held. Dates of staff training were also held in the diary to confirm training staff had attended this year. This included 'core training' such as, moving and handling, fire and food safety. Safeguarding, dementia and the safe management of medicines had also been undertaken. Training had also been provided by the care homes education team on specific topics such as catheter care, hydration and diabetes. The registered manager and a senior care worker were shortly due to commence an end of life training programme run by the local hospice. This would increase their skills and knowledge to care for people who were at the end of their life.

The registered manager explained all new staff completed an induction programme and then worked with an experienced care worker until they felt able to work unsupervised. For those staff that were then eligible, they undertook the Care Certificate (nationally recognised training for care staff). At the time of inspection, nobody had yet commenced the Care Certificate but one care worker was shortly due to start it.

Staff told us they enjoyed their jobs and had the training and skills to meet people's needs. Comments

included "I have had lots of training … it helps us be team spirited as we all work together", "When I first came to work here, I thought "wow" and I still do …. we all do our jobs properly… we pull together as a team … I feel well trained" and "I get lots of training and the registered manager is supportive if I want to do extra training." Two people said, "The staff are good here … I can't grumble … we have a joke and a laugh but they are always on the ball" and "I am happy here because the staff make me happy."

Staff confirmed they received regular supervision from the registered manager. Supervision enabled staff to discuss their work or any training needs they might have and provided an opportunity for their line manager to give feedback about their performance. Staff confirmed the registered manager regularly worked 'hand-on' with care staff and monitored their performance. However, records had not always been completed. The registered manager said they were behind in staff supervisions. They planned to ensure these and appraisals were up to date and had introduced more 'observational' checks of care staff's practice.

People had access to healthcare services, such as their GP, community nurses and dentist. Staff accompanied people on any hospital or health centre appointments. People also had access to specialist services, such as the speech and language therapist (SALT).

Care records contained information of regular consultation with health care professionals. A visiting health care professional said, "I am in every day and if there is a problem they tell me." They said care staff discussed any health issues with them and always acted on any advice given. For example, the service and health care professional were working in consultation with each other for one person who had bladder and continence problems. One health care professional said, "If I want help, I just ask for it … this service has a top grading from me."

People said they had sufficient amounts to eat and drink and were encouraged to maintain a balanced diet. People said they enjoyed the food although they were not involved in menu planning. Comments included, "The food is alright … I would like more variety though", "Food is pretty good … I don't always know what it is but it I don't like it they always find me something" and "The food is lovely here." The provider cooked the main lunchtime meal each day. However, a record of food served was not kept and regular menu plans were not in place. The provider said he decided what people would eat based on the food they bought from the local supermarket. All staff said they would like to see more choice with food at lunchtime and people be more involved in the menu planning. People said they had a choice of teatime meals which the care staff prepared and served.

We recommend that people are involved in making decisions about what they eat and drink. These should reflect their individual choices and preferences.

Good

Is the service caring?

Our findings

Kind and positive relationships had been developed between people and staff. We spent time observing how people interacted with each other. People were relaxed and at ease with staff and the registered manager. This created a homely atmosphere where people felt comfortable and treated Parkview as their home. A recent addition of a parrot in the entrance hall caused much humour and laughter between staff, people and relatives. One person had brought their cat to live with them when they moved to the home. It lived mainly in the person's upstairs bedroom, with the person still able to care for it.

Friendly conversations and laughter between people and staff was heard throughout our visits. People said they enjoyed living at Parkview. Three people said, "It's very nice here … I am very lucky to live here", "Kind? They (care staff) are kindness itself and care for you like they were your own family" and "I am really happy here … the staff are wonderful … more like friends and I don't know how they put up with us." Two relatives said, "Nothing is too much trouble …. staff are kind and caring …" and "Staff are very, very caring."

Staff had a good understanding of each person's individual care and support needs and what they needed to do to meet these needs. The registered manager and staff related well to friends, family and visitors. Staff were thoughtful and promoted people's individual choices and independence as much as possible. Staff spent time with people and engaged them in conversation about their interests, such as reading, colouring and dancing. One person's friend said, "Staff are so kind here … I would give it ten out of ten … it's like people's home here." A visiting health care professional said, "It's very friendly here but very caring."

People said daily routines were flexible and they were able to decide the times they get up, go to bed and how they wish to spend their day. The environment at the service enabled people to spend time on their own if they wished. For example, people relaxed in their bedrooms, the communal lounge, the entrance hall or one of two conservatories. One person's relative visited and they told us they liked to chat privately in a conservatory which the staff promoted. Two people said, "I can do what I want here and I do" and "I get up and go to bed when I want … I am definitely looked after well."

People were treated with dignity and respect by staff. Two relatives said, "Staff are very respectful and dignified" and "They (staff) treat people properly here … I could recommend it (the service) to people as the staff are so well looked after and spoken to properly." Three people said, "They (staff) always keep me covered when they help me get washed and dressed" and "I am always treated with respect … I can't grumble" and "They (care staff) talk to me in a respectful way … they don't talk over my head." Staff responded to people's needs and requests in a sensitive and appropriate manner. When one person needed help with personal care, the care worker gently encouraged the person to visit their bathroom so they could assist them. This was carried out in a respectful and discreet way. People were dressed appropriately, in a style which reflected their preferences. One person wore a protective apron whilst eating. They had chosen to do this in order to keep their clothes clean.

Staff supported people when needed but at people's preferred pace without rushing them. . People were encouraged to use mobility aids if required. For example, one care worker helped one person who had

reduced mobility. Staff offered guidance and gentle support, but encouraged the person to take their time. People told us staff assisted them but encouraged them to do as much for themselves as possible, such as with washing, dressing and walking

People's bedrooms were personalised and reflected their personal interests. Bedrooms contained lots of photographs, posters and other items important to each person. One person had two pieces of moving and handling equipment in their room which did not belong to them. On our second visit, this had been removed from the bedroom and stored elsewhere in the home.

People were supported to maintain important relationships with family and friends who could visit at any time. One visiting friend said, "I visit at all times". A relative said, "We are made to feel welcome at any time and are always offered cups of tea." Good relationships had been developed and regular updates given to family.

Good

Is the service responsive?

Our findings

People received care and support which was written in their care plans and risk assessments. Admissions to the service were planned and managed to ensure people's needs could be fully met before they came to live at Parkview. The registered manager gave examples of people they had not been able to accept into the home whose care had been too complex for them to live there safely. They had recognised they could not meet the people's needs fully. People on respite (short-term) care were accepted. People and their relatives had the opportunity to visit the service and spend time there to make sure they would be happy before they moved in. One relative said, "I went to look at different care places … I chose this one as everything is on the same level and it has a good layout."

Care records, such as care plans and risk assessments, took account of people's views and opinions. Care plans provided some information about how people liked to be supported and were regularly reviewed. For example, one care plan detailed the person's personal care routine and how they liked care staff to support them. Another care plan detailed how a person needed encouragement with eating and drinking. Care plans contained a short personal history and some personal information regarding choices. Whilst care records had been written in a respectful way, the information about people's past lives, hobbies and interests was brief. People were not routinely involved in developing their care plans. The registered manager said they were aware they needed to update the care plans and intended to review the records held and include people and their relatives where possible. Following the inspection, the registered manager made contact with the local authority Quality Assurance Improvement Team (QUAIT) to seek advice and support.

People were supported to follow their interests where possible and take part in local social and community events. Social activities took place in the home and were in the process of being developed and extended to meet people's individual needs. One care worker who was interested in activities organising had taken on the role as part of their care duties. Care staff said activities had recently improved and were being regularly added to. These included games, painting, arts and crafts, singing and dancing, knitting, playing cards, doing jigsaws and armchair exercises. One person liked to tend to the plants in the garden at the home. Outside entertainers visited the home including singers, dancers, musicians, choirs and a professional stage company. The registered manager and care staff took people out individually to the garden centre, shops or for ice-cream. Other events organised by care staff included watching the World Cup on TV with pimms, beer and sherry and having a 'movie night' with a film and supper. Care staff also brought round a trolley once a week which contained old fashioned sweets from glass jars for people to sample. This helped people reminisce from theirs previous lives. We saw people enjoyed this trolley. On our first visit, people took part in a lively singing and dancing session with music from previous eras. This provoked memories for people about their past lives; staff chatted to them about this.

People and relatives knew how to make a complaint and were confident it would be dealt with by staff or the registered manager. Two people said, "No complaints here … they (staff) look after us too well" and "If I was the Queen of England they couldn't look after me any better … no complaints." A relative said, "I feel I could bring anything up if I needed to." None of the people using the service raised any formal concerns with us about their care or treatment. No formal complaints had been received by the service in the previous

twelve months.

Requires Improvement

Is the service well-led?

Our findings

People and those important to them did not have the opportunity to feedback their views about the home and the quality of the service they received. This meant the service did not seek to continually improve based on suggestions or comments received. Surveys, questionnaires or meetings did not regularly happen. The registered manager said feedback was usually gathered on an informal basis through general chats, observations or discussions with people. However, records of these were not kept.

This was discussed with the registered manager who had intended to send out surveys before the inspection took place. However, this had had not yet taken place. This had been due to the lack of management hours as they had been required to cover more hands-on care shifts than normal. Following the inspection, the registered manager immediately planned to arrange an initial survey to people to gain feedback on the choice, type and variety of food and drink served.

Not all the records necessary for the monitoring of the service were held. For example, staff supervision and staff training records. Whilst there were some systems in place to monitor the running of the home, such as the auditing of medicines and care plans, these did not cover all aspects of the service required. For example, no regular monitoring of infection control, health and safety or the environment. As a result, some of the shortfalls we identified during the inspection had not been addressed. The lack of regular auditing was discussed with the registered manager; they agreed with our findings and explained auditing was an issue they knew they had to increase. They said they discussed informally with the provider any issues found but no records were kept. The registered manager had acknowledged this information needed to be recorded and monitored. An example of the issues discussed between the provider and registered manager were the lack of toilets on the ground floor and the poor layout of the laundry area. We discussed this with the provider, who agreed improvement was required and made assurances all issues would be addressed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had worked at the service for many years and a number of the staff had also worked there for several years. The registered manager had a good understanding of their role and responsibilities. They were available out of hours for guidance and advice if staff required it. However, there was no specific organisational structure when the registered manager was on holiday and unavailable. When this occurred the most senior member of staff on duty would manage the day to day running of the service, but not necessarily the management. The registered manager had discussed the need for a designated deputy manager with the provider. This meant the service would be managed appropriately in the registered manager's absence and people, staff and relatives would know who was in charge.

The registered manager was supported by the provider who visited the service six days a week and cooked people's lunch. They did not undertake any formal monitoring of the service.

The service promoted a positive culture. People using the service and staff spoke positively about the

registered manager, the way the service was managed and the open and inclusive atmosphere. All people knew the registered manager well. They regularly worked alongside staff to give them an insight into the care and support required. Care worker comments included, "No door is closed here …. (registered manager) works the floor so she knows what it's like", "(registered manager) is brilliant … absolutely fantastic", (the registered manager) leads the team, I have a lot of respect for her" and "We (staff) all work together". A health care professional said, "I come in here nearly every day … it is well managed … staff are always visible and if I need a hand I just ask for help."

All staff were aware of their roles and responsibilities. They felt motivated, enthusiastic and supported. Staff, without exception, spoke passionately about how they enjoyed their jobs, felt part of a team and were listened to. Their comments included, "I love it here … truly … it's home from home and we all pull together as a team … it's very team spirited", "It's really homely here … everybody gets on and I feel confident (the registered manager) would be supportive as we are encouraged to air our views" and "I love it here … I feel part of a team and I just have to ask and I will be supported." Staff meetings took place but not on a regular basis. All staff said they would like these meetings to take place more frequently so they could discuss any issues, concerns or changes in care practice. This was discussed with the registered manager who had planned for them to be introduced on a regular basis.

Incidents and accidents were recorded by staff and monitored by the registered manager. Where necessary, any action was taken to reduce avoidable risks or the appropriate professionals contacted. The service regularly liaised with health and social care professionals. A health care professional said the service made appropriate referrals and always acted on their advice or recommendations.

All servicing and maintenance of equipment was carried out in accordance with the necessary contracts.

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 The provider did not follow the requirements of the Mental Capacity Act (2005).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Premises and equipment were not always clean, suitable and well maintained for their intended purpose. Environmental risks to people had not been assessed and managed. Infection control measures were not in place to reduce and minimise the unnecessary risk of infection to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes for the assessment, monitor and improvement of the quality and safety of the service were not in place. Feedback from people, and others, on the quality of the service delivered was not sought. Records required for the running of the service were not always held.