Runwood Homes Limited

Park View

Inspection report

Priory Road
Warwick
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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?	Good

Summary of findings

Overall summary

We inspected this service on 8 November 2018 and the inspection was unannounced.

Park View provides accommodation with personal care for up to 64 people. The home has three floors which each have communal lounges and dining areas and there are pleasant enclosed gardens which are accessible from the ground floor. At the time of this inspection, 55 people lived at the home, some of whom were living with dementia.

People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A requirement of the services' registration with us is that they have a registered manager. 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. At the time of this inspection the home had a registered manager in post.

We last inspected this service in December 2017 and found improvements were required in the safety of the service and how well led the service was. The overall rating of the service was Requires Improvement.

As part of this inspection, we looked to see whether the provider had made the required improvements. We found they had, and improvements made by the registered manager and provider ensured people received a safe, effective, caring, responsive and well led service. At this inspection we gave a rating of Good.

The registered manager had been in post for 12 months at the time of our inspection visit. Staff told us the home had improved in that time because they now had a consistent management team. People and staff told us the registered manager was visible in the home, understood the needs of the people who lived there and responded to any concerns raised.

There were enough staff to provide safe care. Staff told us they worked well as a team, because they were allocated specific responsibilities by the care team manager while they were on duty. The suitability of staff was checked during recruitment procedures to make sure they were safe to work at the home. New staff were appropriately introduced to the home and later had regular refresher training and were supported to develop their skills and to obtain nationally recognised qualifications.

People's individual risks were assessed and care plans were written to minimise the identified risks. When accidents did happen, there was a process to analyse what had happened to ensure appropriate action had been taken and minimise future risks.

The environment was supportive of people's needs. The home was clean and tidy, and staff had received training to understand how to reduce the risk of infection being transmitted from one person to another.

The registered manager and care staff understood the principles of the Mental Capacity Act 2005 (MCA) and how to put these into practice. Staff promoted the rights and choices of people who lived in the home by offering them the opportunity to make decisions about their daily lives.

People's nutritional and healthcare needs were assessed and kept under review. People had sufficient to eat and drink during the day. Healthcare professionals visited people regularly to review their care and treatment. Managers and senior staff completed audits and stock checks of medicines to ensure people had received their medicines as prescribed.

Staff received training in dementia awareness and dignity and respect, which enabled them to understand people's complex needs and to support them with empathy and compassion. Staff took care to ensure they had positive interactions with people as they carried out their roles. People were encouraged to maintain their interests and to socialise.

The provider and management team checked the quality of the service people received and implemented improvements.

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's needs had been assessed and risks to their safety were identified and managed effectively. Staff had been recruited safely and there were enough staff on duty to meet people's needs and respond to their requests for assistance. Medicines were stored safely and the provider had checks in place to ensure people received their medicines as prescribed. The home was clean and tidy and staff followed good infection control practice.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The home was well-led.

People, relatives and staff felt the management team were approachable and would listen to any concerns raised. Staff understood their responsibilities within the home and felt supported in their roles. There were quality monitoring systems in place to identify any areas needing improvement. Where issues had been identified, action had been taken to address them.

Park View

Detailed findings

Background to this inspection

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

This comprehensive inspection visit took place on 8 November 2018 and was unannounced. The inspection was undertaken by one inspector, a bank inspector and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had similar care needs.

This service was selected to be part of our national review, looking at the quality of oral health care support for people living in care homes. The inspection team also included a dental inspector who looked in detail at how well the service supported people with their oral health. This includes support with oral hygiene and access to dentists. We will publish our national report of our findings and recommendations in 2019.

Prior to our inspection visit, we reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The commissioners did not share any concerns about the service.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was very detailed and we could review the information in the PIR during our inspection visit. We found the information in the PIR was an accurate assessment of how the service operated.

During our inspection visit we spoke with the registered manager about their management of the home. We spoke with three care team managers (senior care staff), three care staff, the activity co-ordinator, the dementia services manager and the cook about what it was like to work at Park View. We also spoke by

telephone with a healthcare professional who frequently visited the home during the inspection visit.

Many of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Some people could tell us what it was like living at Park View. During the inspection visit we spoke with nine people who lived at the home and six relatives/visitors. We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We reviewed four people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at staff training records, records of complaints and reviewed the checks the registered manager and provider made to assure themselves people received a safe, effective quality service.

Good

Is the service safe?

Our findings

At our last inspection in December 2017 we found the safety of the service required improvement. This was because risks were not always fully mitigated. At this inspection we found the provider had made the required improvements and the safety of the service is now rated as 'good'.

People's individual risks were assessed and care plans were written to minimise the identified risks. Risks to people's communication, memory, mobility, continence, fluid and nutrition, sleeping, health and skin were assessed. Where people needed support to move around, their care plan explained the equipment and number of staff needed to support them to move around safely. One person was at risk of falls from their bed. They had a crash mat and a sensor mat in their room, so staff would be alerted straight away. Staff told us they lowered the person's bed at night to minimise the risk of injury if they fell, and records showed staff checked the person every hour during the night. We saw people who chose to stay in their bedrooms had their call bells to hand so they could easily call for assistance.

Improvements had been made in managing the risks to those people who chose to smoke. To keep one person safe when they smoked, their cigarettes and lighter were kept in a safe place and they had a fire-retardant apron to wear. They were always accompanied by staff when they went outside for a cigarette.

People at risk of sore skin had been prescribed pressure relieving mattresses. Their current weight was recorded in the care folder in their bedroom so staff could ensure the mattress was set at the right pressure for the person's weight. Senior staff regularly checked mattresses to ensure the correct pressure setting was maintained.

The provider had assessed and mitigated the risks of fire. Staff received training in fire safety and attended monthly fire drills. The fire alarm and fire-fighting equipment were regularly tested and serviced. People had personal emergency evacuation plans to ensure their individual risks were known and managed in the event of an emergency evacuation. Their bedroom doors had colour coded stickers so staff could see at a glance the level of support they would need in the event of an emergency.

There were enough staff to provide safe care. People's assessed needs and dependencies were 'scored' to enable the provider to ensure there were enough staff on duty to support everyone safely. Staff confirmed there were enough staff to provide the care outlined in people's care plans, as well as respond to their emotional and well-being needs. They told us they worked well as a team, because they were allocated specific responsibilities by the care team manager while they were on duty. One person needed to have a high level of observation because they could sometimes display behaviours that were challenging to others. A staff member confirmed the number of staff on duty enabled them to maintain the level of observation set out in the person's care plan.

People and relatives did not raise any concerns about staffing levels and told us there were staff available if they needed support. One person told us they felt safe because if anybody living with dementia accidently walked into their bedroom, "You just press the bell and somebody comes." Another person told us, "If

anything happens, they are there to help me. They check on us all through the night and offer a drink if we can't sleep."

At our last inspection we found the provider was reliant on agency staff to cover shifts because of a high level of staff vacancies within the home. The registered manager told us the use of agency staff had reduced, but acknowledged it increased at certain times of the year due to holidays or because of long term sick leave. They told us they continued to recruit new staff and in the meantime tried to use agency staff who regularly worked in the home to maintain continuity of care. A member of staff confirmed, "The use of agency staff has got better and we try and put them on a floor they have already worked on."

The provider had an effective recruitment process and staff recruited were suitable for the role they were employed for. References had been requested and checked and DBS (Disclosure and Barring Service) clearance had been returned and assessed by the management team before staff started work.

People were protected from the risks of harm or abuse. The provider's safeguarding policy was displayed in the staff room, to ensure staff were constantly reminded of the process and their responsibility to report any concerns. Staff had training in safeguarding and knew the process to protect people from the risks of harm. A member of staff told us the registered manager had taken effective action to minimise the risk of a reoccurrence when they had reported a concern. Another member of staff told us, "We have a duty of care to protect every resident."

Medicines were managed and administered safely. People's medicines were stored safely in locked trolleys in medication rooms. Medicines were delivered in pre-packed trays, colour coded for the time of day, which minimised the risks of errors. Each person had a medicines administration record (MAR), which staff signed each time they gave people their medicines. Managers and senior staff completed audits and stock checks of medicines to ensure they had been given when they should.

At our last inspection we found that the application instructions for topical medicines applied directly to the skin were not always clear. Since that inspection the registered manager had introduced a body map into the care folder in people's bedrooms which showed where the creams should be applied and instructed staff how often it should be applied. Care team managers checked that staff signed and dated each time they applied prescribed creams.

For medicines that were administered only 'when required', such as mild pain relief, staff counted and recorded the number of tablets remaining to make sure there were no errors and there were always sufficient medicines available for the person. However, there were not always guidelines in place for when people should receive their 'when required' medicines. Although staff felt confident these people would be able to say when they were in pain, the deputy manager told us their expectation was that guidelines should be in place, and assured us this would be done.

Where people had to have their medicines given to them disguised in food or drink, the person's representative, staff and other healthcare professionals had been involved in making the decision in the person's best interests. Confirmation from the pharmacist ensured that the chosen method of administration was safe and appropriate.

The home was clean and tidy, and staff had received training to understand how to reduce the risk of infection being transmitted from one person to another. They were aware of the need to use gloves and aprons when providing personal care. Infection control and prevention measures were in place in the laundry area of the home, and in the kitchen. In the kitchen there was a written schedule for daily, weekly

and monthly cleaning tasks, to ensure nothing was overlooked.

At our last inspection we found lessons were not always learned when things went wrong. At this inspection we found the registered manager had implemented a more robust process to analyse accidents and incidents to ensure appropriate action had been taken and minimise future risks. For example, all falls were reviewed monthly to identify any patterns or trends and whether appropriate professional referrals for advice had been made. There was also an assessment of whether the actions taken had been effective in reducing risk.

Good

Is the service effective?

Our findings

At this inspection, we found staff had the same level of skill, experience and support to enable them to meet people's needs as effectively as we found at the previous inspection visit. Staff continued to offer people choices and supported them with their dietary and health needs. The rating continues to be Good.

People's individual risks were assessed using recognised assessment tools, such as the Waterlow to assess risks of skin damage. Risks were minimised through care plan guidance for staff about any equipment and the number of staff needed to support people safely with walking, eating, drinking, and sleeping. The aim of the care plans was to promote people's independence as far as possible.

New staff were appropriately introduced to the service and had a period of working alongside more experienced staff (shadowing) until they felt confident in their role. A senior member of staff told us the period of shadowing was flexible and depended on previous experience and qualifications. The registered manager assessed new staff in the first few months of their employment to ensure they had the right values and attitude to work effectively with people who lived at Park View.

Staff told us they had regular refresher training and were supported to develop their skills and to obtain nationally recognised qualifications. Staff who showed a talent for a particular element of care, in dementia care for example, were encouraged to develop a specialism and were invited to become lead staff in that area, according to their interests. One senior member of staff explained how the training staff received enabled them to provide effective person-centred care. They told us, "The care is outstanding with all the staff because of their training. They are more aware of dementia now and they are more aware of the person as an individual."

Staff told us the registered manager was supportive and was always available to answer any queries. During the shift handover meeting, staff shared information about how people were, any particular needs, health issues and appointments for the next staff shift to manage. Handover records showed how the care team manager managed the staff team, by allocating specific responsibilities to care staff for serving hot drinks, checking equipment was maintained safely and disposing of clinical waste. Staff told us the team-working arrangements were effective.

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. We checked whether the service was working within the principles of the MCA and whether they had the appropriate legal authority.

People's ability to make decisions about their care and support had been assessed and was detailed in their care plans. For example, people's care plans identified whether they had the capacity to consent to living at the home. Where they had not consented and the decision had been made in their best interest, the

registered manager had applied for the authority to make the decision on their behalf. People's care plans included the name of their preferred representative who should be consulted in decision making.

Staff demonstrated they understood the principles of the Mental Capacity Act 2005. Staff promoted the rights and choices of people who lived in the home by offering them the opportunity to make decisions about their daily lives. This included decisions about where they wanted to spend their time and what they would like to eat. Staff ensured people had a real choice in making decisions by obtaining people's consent before providing support to them. For example, at lunch time staff checked with people they were serving before doing anything, such as adding gravy to their plate or clearing a plate away.

People were supported to maintain their health with a choice of meals and snacks, which met their dietary requirements. At lunch time the dining tables were laid with a cloth, cutlery, menus and flowers, which enhanced people's mealtime experience. Menus were in a written and pictorial format, and at lunch time people were shown the choice of meals to enable them to make a choice by sight and smell of the meal. Whilst people were offered choices, it was clear staff were familiar with people's likes and dislikes in relation to food. The food when it was served looked hot and appetising and people who had finished their meals were asked if they would like more. People who needed specialist diets and assistance to eat, were supported effectively by staff who understood and cared about the individual's dietary needs. Some people had specially adapted plates and plate guards so they could continue to eat independently.

People were asked about their dietary needs, preferences and any allergies before they moved into the home, and these were included in their written care plans. People's dietary requirements, such as soft or diabetic meals, were listed in the kitchen, to make sure menus catered safely for each person. The cook told us they had a conversation with people when they moved in, to check they had mentioned every need and preference.

People were regularly weighed to make sure they ate enough. Where people lost weight and their body mass index was outside of the normal range, staff monitored their food and fluid intake and people were weighed weekly, to make sure any further weight loss would be identified quickly and action taken. Where people were identified as at risk of poor nutrition, they were referred to dieticians and the speech and language teams, to make sure appropriate amendments were made to their diet.

People's care plans included their medical history, which ensured staff understood risks to their health and the signs of ill-health. Healthcare professionals visited people when necessary, and two local GPs held a weekly surgery at the home. One healthcare professional told us, "Staff know their residents well so they know if something is up with them and they take our advice on board."

Staff told us that if a person needed to be admitted to hospital, they sent a 'hospital admittance form' with them. The form gave a 'snapshot' of the person's basic needs such as any support they needed with communication, eating and drinking or mobility. The form assisted other healthcare professionals to meet people's care and support needs as they moved between services.

The environment was supportive of people's needs. It was well decorated, inviting and directional signs in words and pictures supported people to identify rooms and find their way around independently where possible. People could choose to sit in a variety of communal areas or the easily accessible gardens. Many communal areas had large windows overlooking park land or areas of interest which gave people an understanding of the changing seasons and provided topics of conversation. One relative when providing feedback commented, "It's a lovely place, modern and airy and light." There was a 'Victorian-style' tea room, which opened out onto a garden terrace, where people could entertain their visitors with a hot drink, cake

and biscuits. A member of staff told us about one person who chose to spend time alone in their room, but came to the tea room with their visitors. The member of staff said, "[Name] is always smiling when they come back upstairs. They say, 'I've been in the garden'."

Good

Is the service caring?

Our findings

People received the same level of kind care and support as at our previous inspection. The rating continues to be Good

A member of the management team told us good care was about, "Talking to people, having time to care." Another staff member told us, "Just having that comfort and somebody to be there is what makes people feel safe. I love helping people and making a difference." Staff received training in dementia awareness and dignity and respect, which enabled them to understand people's complex needs and to support them with empathy and compassion. We saw this training translated into staff's working practice. One person described the staff as 'first class' and said, "If you haven't got anything, they will do shopping for you." Another told us, "The home is very caring towards me. The carers offer to help me, I'm quite happy here."

Staff took care to ensure they had positive interactions with people as they carried out their roles. Staff spoke to people by name, asked people how they were feeling and listened to their responses. One member of staff working on the ground floor delivered some medicines for a person on the second floor. This staff member took the opportunity to go around the lounge on the third floor and speak to each person by name before returning to their own unit. This interaction gave people a feeling that they mattered to the staff supporting them.

We saw moments of caring thoughtfulness throughout our inspection visit. A relative was sitting with their family member and asked if they could speak with us. The person became anxious as their relative left them and this was immediately recognised by a member of staff. The staff member went and sat next to the person, filling the space left by the person's relative. They put their arm around the person and provided them with physical and emotional assurance. Another staff member responded with courtesy and kindness towards a person when they became anxious. The staff member sat next to the person, spoke reassuringly and encouraged them to look forward to pleasurable activities, such as some personal nail care later in the day.

People's care plans included a 'My Day' section, which recorded what was important to the person, their preferences for how they spent their time and how staff should reassure and comfort the person. Everyone's name was on their bedroom door with an emblem they had chosen that represented them as they wished to be thought of. This acted as a visual reminder to staff about topics of conversation that people might enjoy.

The provider's policy to ensure people felt cared for, included each person having a named 'key worker' with responsibility for checking their needs were met and who could get to know them well. One member of staff told us how the keyworker system benefitted people and explained, "You have to develop a good relationship with them so they feel they can come to you." A relative pointed to a member of staff who was their family member's keyworker. They described this staff member as 'particularly good' and went on to say, "She has got a very sympathetic manner." Another relative had recently commented, "I think this is the essence of good care, building a joint relationship with the person and the relatives concerned."

People's care plans were written in a way that promoted a caring response from staff. For one person with complex needs, staff were guided to, 'speak slowly, explain, use short sentences' and if the person became anxious, to 'hold their hand, gently stroke their face'. Their care plan explained which kind of music the person preferred to listen to, which could reduce their anxiety. The guidance for staff reminded them which radio station to leave on a low volume at night, which comforted the person.

People's independence was promoted. One person particularly spoke about how, with staff support, they had regained some independence with their mobility. They told us that due to illness they had been unable to walk for several months, but with encouragement from staff they had started to walk to their bedroom window and back. They were pleased to tell us, "For the last fortnight I have walked to the dining room for my meals."

Staff understood people's right to be treated with respect and dignity and to be able to express their views. There was a poster in the reception area, reminding staff to "Remember, we work in our residents' home, they do not live in our workplace." As a sign of understanding that dignity could mean different things to people because of their individuality and diversity, the provider had created a 'dignity tree'. The tree was covered in people's written opinions of what dignity meant to them. We saw staff behaved in the way people had said demonstrated 'dignity and respect'. People were respected and their dignity was promoted through staff's behaviour and attitude towards them.

Good

Is the service responsive?

Our findings

At this inspection, we found people continued to receive care that was responsive to their needs and the rating continues to be Good.

People made positive comments to us about living at the home. One person told us, "The staff they have got are first class." Another told us, "It's absolutely wonderful, I've never looked back since coming here."

People had care plans that were personalised to their needs. These told staff how people needed to be supported and the level of assistance that was required. People's care plans included a 'life history' which helped staff to understand their interests, motivation and anxieties.

Staff told us they could respond to people's emotional needs because they worked with them regularly and knew them well. Staff explained that changes in the deployment of staff meant they mostly worked in the same areas of the home so they could build relationships with people who knew and recognised their faces. Staff told us this was particularly supportive of people living with dementia who could sometimes become anxious during care interventions. For example, we were told about one person who could decline personal care because of their anxiety. A staff member explained, "Now there are familiar staff, [name] is more willing because she recognises them." Another staff member explained how consistency of care staff for one person made a 'positive start to their day' and another told us it made them proud to see, "Our residents content and watching them smile through the day because they recognise staff."

The home provided care for people at the end of their life. The registered manager told us they worked with other healthcare professionals to ensure people had a dignified and pain free death. Where appropriate, anticipatory medicines were in place to ensure people had immediate access to medicines that would relieve their symptoms.

We spoke with one relative whose family member had recently died whilst being cared for at Park View. They spoke very positively about the care their family member received during their final days. They told us, "The care was fantastic, they had time to listen, some of them were like relatives, they really cared." Another relative had written complimenting staff for, "Clearly explaining to me what was happening, and that what was happening was exactly normal and what would come next."

The provider complied with the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced to make sure people with a disability or sensory loss are given information in a way they can understand. We saw people were encouraged to communicate in ways which suited them and staff followed the guidelines in people's communication plans. For example, we heard staff using short, simple sentences to ensure people could more easily understand the information they were sharing. Where people had a sensory loss, staff made sure people had access to their hearing aids and glasses. Pictorial menus and visual prompts provided accessible information for people living with dementia.

There was an activities co-ordinator who worked five days a week. The list of weekly activities available to

people were displayed in the corridors, the lift and in each person's bedroom, to encourage them to maintain their interests and to socialise. The activities co-ordinator told us two of the activities each week were around food and could include baking, 'mocktails', buttering bread and preparing vegetables. They told us this not only gave people a sense of meaningful occupation, but were also good activities to prompt reminiscing. There were also knitting and walking clubs, and some people enjoyed local walks or trips further afield to the shopping centre and local garden centre. The week before our visit the activities co-ordinator had taken some people to the cinema to see a film they had expressed an interest in. One relative told us, "The activities co-ordinator does her best with the residents, even those who can't really engage."

The registered manager told us that activities were not just about group and planned entertainment, but also about general day to day activities. For example, chatting over a newspaper or discussing what people wanted to wear in the morning and making the time meaningful for people. We saw staff developing this approach as they went about their care tasks by talking to people about the view out of the window or about a poppy display in the local church.

Staff were responsive to promoting people's independence to support their sense of wellbeing. We saw people used the many communal spaces around the home throughout our inspection visit. People were encouraged and supported to maintain their mobility by using a frame to walk with. Staff were patient with people and let them move from place to place at their own pace. There was a stack of CDs by the CD player in reception, which enabled and encouraged people to play music of their choice. In one of the communal rooms there was a piano and jig-saw puzzles, which anyone could play.

There was a suggestions box and regular meetings for people and their representatives or relatives to make sure their views about how the service was run were known. Every Thursday evening the registered manager held a 'surgery' so people could discuss any issues or concerns. The provider also had a complaints procedure displayed in communal areas which people and relatives understood. People felt able to raise concerns without fear of discrimination. One relative had recently commented that they particularly appreciated, "Being able to raise issues with staff without, at any time, their getting into any sort of defensive mode."

We looked at the complaints register and saw there had been seven complaints in 2018. We found complaints had been investigated and there was information about any recommendations or action that needed to be taken to prevent similar issues in the future.

Good

Is the service well-led?

Our findings

At our last inspection visit we found changes in the management team meant some people experienced inconsistencies in the delivery of care and some risks were not consistently managed. At this inspection we found improvements had been made to the governance of the home and the rating is now Good.

The provider had responded to the issues we identified during our previous inspection. They had implemented body maps in people's care folders, to ensure staff had the guidance they needed to apply topical creams safely and effectively. They had a written risk assessment and guidance for staff to support a person who smoked, to minimise the risks of harm to the person and to others. They had also introduced a more robust system to review accidents and incidents to ensure appropriate action was taken to minimise risks.

The provider's policies were displayed in the staff room to ensure staff were able to access, read and work within the policy framework. Staff understood their roles and responsibilities within the home because they were allocated at the start of each shift. This ensured that checks on areas such as equipment and cleanliness were carried out in accordance with the provider's expectations. For example, the provider's policies and procedures for minimising environmental risks were well established and followed effectively by the whole staff team. In reception the CQC key lines of enquiry (KLOES) were displayed to remind people, staff and visitors of the provider's and registered manager's aims to provide a consistent quality of care.

At the time of this visit, the registered manager had been in post for 12 months and was now registered with us. Staff spoke positively about the registered manager and how the home had improved now they had a consistent management team. A typical comment was, "She is very good because she knows what she wants to do and she is very focussed. She likes to know about all the residents. Since she has been here, the home has blossomed." Staff told us the registered manager was visible in the home and one explained, "The residents know she is the manager. She comes around and doesn't just stay in the office." This was confirmed by people and their relatives. One person told us the name of the registered manager and said, "If she is walking past my room, she calls in to see me."

A healthcare professional who regularly visited the home also spoke of the positive impact the registered manager had on the home. They told us, "She runs a tight ship and staff know it and what is expected of them. Having that consistency has definitely made a difference."

Staff told us they felt improvements had been made to the services provided since our last inspection visit. They particularly mentioned that the number of permanent staff had improved and told us that now staff regularly worked with the same people, this had a positive impact on people's wellbeing. Staff felt happy in their job roles and told us they were supported through one to one supervision meetings, team meetings and training opportunities. We looked at the minutes of recent meetings and saw they were used to discuss risks and improve outcomes for people. For example, recent topics included falls and ways of reducing them, and encouraging people who had lost weight to eat high calorie snacks.

People's views and feedback was sought through meetings and questionnaires. Meetings and regular surveys enabled people to make suggestions about what food they would like on the menu and what activities they would like to participate in. This supported the registered manager to ensure people were happy with the service and received the care and opportunities they wanted whilst living at Park View.

Improvements had been made to the quality assurance system to ensure people received a safe, effective and responsive standard of care. Audits and checks were planned for, and undertaken on a daily, monthly or annual basis. For example, each day a care team manager completed a 'floor audit' to check people had their sensor mats in place and their call bells to hand. Where issues were identified, actions had been taken to make the required improvements.

The registered manager had a home development plan and was looking at ways of improving care delivery. For example, they had recently introduced a 'resident of the day' where each day a person had a review of all their care needs to ensure the care they received was responsive to any changes in their abilities. The registered manager also planned to introduce staff champions in areas such as infection control and end of life care to take a lead in these areas and share best practice with other staff members.

The registered manager continued to build relationships with other organisations and healthcare professionals to benefit both the people who lived at Park View and the wider community. For example, they continued to work with two advanced nurses who were funded through a local charity. The nurses were attached to local GP surgeries and visited the home twice weekly with a GP, or if a need was identified. We spoke with a healthcare professional who confirmed that the scheme had reduced the need for emergency treatment and hospital admissions.

It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had conspicuously displayed the ratings from our last inspection in the home.