New Park House Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 7 June and was unannounced. At our previous inspection in July 2015 we had concerns that people were not always supported to consent to their care and the systems the provider had in place to monitor the quality of the service were ineffective. At this inspection we found that no improvements had been made and care being delivered was not safe, effective or well led. We have rated this service as Inadequate and placed the service into special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months.

New Park House provides nursing and personal care to up to 95 older people. At the time of this inspection 86 people were using the service.

There was a new manager in post who was yet to register with us. 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 provider was not protecting people from the risk of harm through neglect as they did not ensure that there were sufficient staff delivering care that were trained and competent. Some staff were delivering care they were not trained to do.

People's medicines were not managed safely. People were not always given the correct dose of their prescribed medicine at the prescribed times and some people had not been administered their medicine as the provider had not ensured sufficient stock was available at all times.

The provider did not consistently follow the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care, treatment and support.

Systems the provider had in place to monitor and improve the quality of the service were ineffective. Records were inconsistent and disorganised. Audits had not identified the shortfalls in the care being delivered.

People did not always receive care that met their individual needs and preferences .Some people were not engaged or stimulated by activities or their surroundings. Some people sat for long periods of time with no interactions.

People were not always treated with dignity and respect and their right to privacy was not always upheld. People's choices were not always respected as they were not always able to go where they wanted to go when they wanted to.

People's nutritional needs were not always met and health care support was not always gained in a timely manner. People had lost weight and health care advice had not been sought.

There was a complaints procedure and people knew how to use it. People and relatives we spoke with told us that the new manager and staff were kind and approachable.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always protected from abuse in the form of neglect.

Risks to people were not always assessed and minimised.

There were insufficient suitably trained staff to safely meet the needs of people who used the service.

People's medicines were not managed in a safe way.

The provider followed safe recruitment procedures.

Is the service effective?

Inadequate

The service was not effective.

The principles of the MCA were not always followed to ensure that people consented to their care.

Staff were not suitably trained and did not always have the skills to meet the needs of those in their care.

People's nutritional needs were not always met and health care advice was not always followed or gained in a timely manner.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always treated with dignity and respect.

People's right to privacy was not always upheld and their independence was not ways promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their assessed needs.

Some people were not offered opportunities to engage in activities of their choice.

The provider had a complaints procedure in place and people knew how to complain.

Is the service well-led?

Inadequate

The service was not well led.

Systems the provider had in place to monitor and improve the quality of the service were ineffective.

People were receiving care that was unsafe and the provider was in breach of several Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post.

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Detailed findings

Background to this inspection

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

This inspection took place on 7 June 2016 and was unannounced. It was undertaken by four inspectors.

We reviewed the information we held on the service. We looked at the last inspection report and notifications the provider is required to send us by law. We had received information of concern from the local authority and two health care professionals prior to this inspection about the welfare and safety of people who used the service.

We spoke with 12 people who used the service .We spoke with four relatives, five care staff and a nurse. We spoke with the new manager and an operational manager.

We observed the care and support people received in the service. This included looking in detail at the care and support eight people received, and if it matched the planned care we saw in their records. We looked at the way in which people's medicines were managed. We also looked at people's daily care records and records of their medication.

We looked at the systems the provider had in place to monitor the quality of the service. We did ths to see if they were effective.

Inadequate

Is the service safe?

Our findings

We observed people's care throughout the service and saw that they did not always get the care they needed in a safe way and at the times they needed it. This was due to there being insufficient suitably experienced staff being available and deployed appropriately across the home. We saw in one area of the home there was a senior member of staff and two carers. The senior member of staff who was responsible for administering medication was supporting people to have breakfast in the lounge. This meant they were unable to start the medication until midmorning as the lounge could not be left unsupervised as the care staff were supporting people to get up and dressed for the day. This meant that people were not having their prescribed medication at the times it was required to be given and there would be insufficient time between the next doses. This could result in a person having too much medication and becoming unwell. We saw in another area of the home there was one inexperienced agency member of staff who was administering medication. This nurse was the only nurse on duty. We found that people were experiencing a delay in receiving their medication due to the inexperience and lack of knowledge one member of staff had of people's needs. Some people's medication had been prescribed to be given at an exact time and this had not happened. This meant that people were at risk of ill health due to unsafe administration of medication.

Some people had been assessed as requiring encouragement to eat and drink. We saw two people were sat in the lounge and were given their breakfast at a small table. Both people's care plans stated that they needed encouragement to eat. We saw that staff did not have the time to sit with people during their meals and both people did not eat the all the food presented to them. One person was left with a bowl of cornflakes which they spilt over themselves, however staff had not noticed this and they were left with wet clothing.

One person required support with their continence needs. We found they had not been supported for a period of five hours. A visitor prompted the staff by asking them when they had last had their needs met and staff informed them it was now due. When the person was supported to get up and attend to their needs it was apparent that they had been incontinent. We were unable to ascertain how long this person had been sitting like this as staff had not supported them to move for several hours. One member of staff told us: "I think sometimes we could do with more staff as there are only two staff in the main lounge and if someone needs the toilet that leaves one member of staff until someone else is available, I've never felt it's been unsafe but the residents have to wait longer than they should". A relative told us: "There have been occasions when there has been two staff members in the big lounge and they had to go off and do other things, leaving no staff in there for 10 minutes, one person needed the toilet and we couldn't find anyone to take them. We did wonder whether it was safe to leave the room unstaffed in case anyone tried to stand and fell".

These issues are a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of unsafe care due to staff not having the correct information to be able to care for people safely. Care plans and risk assessments were unclear and confusing. We saw gaps in people's records

when people should have had care delivered. For example one person required pressure care every two hours, which would reduce the risk of gaining a pressure area on their body. We saw at times there was up to a four hour gap in the recordings of when they had last received their required care. We also saw that this person had not had their prescribed topical cream for three days as it had run out of stock. This person had three pressure areas which required treatment from the district nurses. Being without the prescribed cream and safe pressure care could result in the person being in pain and discomfort which was avoidable.

We saw a risk assessment for another person which stated that they required observations every 15 minutes when they were in their room as they were at risk of self-harm. We saw no records to say these checks were taking place and staff we spoke with told us they were not aware of this risk assessment for this person.

We found that untrained staff were carrying out procedures that they required training to do. One person required support to maintain their nutrition through a tube. This is called 'PEG' feeding. Two members of care staff told us they regularly supported this person with their PEG although they had not received the training to do so. This put the person at risk of receiving unsafe care and treatment.

We saw several people who were being cared for in bed did not have any way of calling for assistance if they needed it. Although staff called into visit people in their rooms, several people had no call bells available to them. It was unclear how these people would be able to call for help if they needed it.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with knew what constituted abuse and told us they would report it if they suspected any harm had come to people. However the provider was not protecting people from the risk of abuse through neglect and poor care by ensuring that people were being supported by trained, competent staff and that people received their planned care in a safe way and their medication as it was prescribed.

Safe recruitment procedures were followed to ensure that new prospective staff were checked for their fitness to work with people. References and Disclosure and Barring (DBS) checks were completed to ensure that the prospective staff was of good character. The DBS is a national agency that keeps records of criminal convictions.

Inadequate

Is the service effective?

Our findings

At our previous inspection we found that the provider did not always follow the principles of The Mental Capacity Act 2005 (MCA). 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. At this inspection we found that there had been no improvements and people were still not always consenting or being supported to consent to their care, treatment and support. We saw that two people had a Do Not Attempt Resuscitation (DNAR) record on their care file which had been put in place at a time when they had been unwell and unable to consent. These people had recovered and had the capacity to consent to agree to a DNAR if they so wished. The DNAR's remained in place at the front of the people's care files without having been reviewed and this left people at risk of not having any lifesaving care at a time they may have needed it.

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

Several people had been referred to the local authority for a Deprivation of Liberty Safeguards assessment (DoLS) . The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. However the management and staff could not tell us who was subject to an authorised Deprivation of Liberty and who was not. The service had restrictions of locked doors from one area to another and to the outside. In one lounge the patio window to the garden was locked. It was a sunny, hot day and we were told that the door could not be opened because of one person who may wander into the garden. Consideration to the other people who used the lounge had not been given and there was no risk assessment in place to minimise the risk of this person wandering off if the door was open. This meant that the action being taken was not the least restrictive and people were deprived of their liberty to access the outside garden area.

These issues constitute a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not always met. We saw in two people's care records that they had lost weight over a period of five months. We asked a senior member of staff if they knew what had been done but they were not aware these people had lost weight. The senior member of staff told us these people should have begun to be weighed weekly and health advice should have been sought to ascertain why they had lost weight, however this had not happened. We observed that one of the people who had lost weight had been assessed as requiring encouragement to eat. We saw that their meal was left in front of them and no support was offered and they spilt the majority of the food onto themselves without staff noticing. At lunch time the manager arranged for kitchen staff to assist serving people which meant that care staff were able to sit and support people to eat their meals.

Staff recorded what people ate and drink but these records were ineffective as they were not checked or totalled at the end of the day. There were no expected totals of fluid recorded, so staff would not know how much a person should be encouraged to drink. This meant that people who were at risk may be not having sufficient to eat and drink to remain healthy.

We saw that several people being cared for in bed had drinks however they were out of their reach. We saw one person trying to drink out of a cup with a lid on it; they were unable to use it and were not able to get to the fluid in the cup. We asked if they wanted a straw which they did and they were then able to drink it. We observed that they drank it quickly as if they were very thirsty. This meant that people were at risk of dehydration as they were not being supported to drink the fluids that were being made available to them.

These issues constitute a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received health care support from other professionals. People saw their GP, consultants and district nurses. On the day of the inspection we saw one person was being supported to the hospital as they were showing signs of being unwell. However the advice and support was not always gained in a timely manner, for example, people who had lost weight had not yet been supported to see a health professional.

Staff told us they felt supported to fulfil their role. One staff member told us: "I like doing my best for the residents. Yes, I think we get enough training and we have supervisions with the unit managers and get to talk through any issues". However we found that staff were being asked to complete tasks they required training to do and they had not received this training, for example 'PEG' feeding. This put people who used the service at risk of harm.

Requires Improvement

Is the service caring?

Our findings

People who used the service and their relatives told us they felt that the staff were kind and caring. One person said: "They [the staff] always do their best for you, they help you when you need it. I've never had to complain about anything, everything is good here". We observed lots of positive interactions between staff and people who used the service. However from some of our observations we found that people were not always treated with dignity and respect. Several people were being cared for in bed in a state of undress. One person told us: "I would like to get up but I feel embarrassed".

We saw one person who was living with dementia who had taken their false teeth out and put them on the table in front of them. No one asked them if they wanted their teeth in or putting safe and they remained there all day. We saw two people had hospital wrist bands as a result of attending hospital. Staff had not thought to take the wristbands off. We saw a high proportion of people with long dirty fingernails who would have required support with keeping them clean. Staff we spoke with had not recognised that people's nails required cleaning.

We observed that there were times when staff supported people to move in wheelchairs without explaining to them what they were going to do and we saw some people were asked to sit down when staff were unavailable to support them and they had gotten up to go somewhere. This meant that people were not always being treated with dignity and respect and their choices being acted upon. Staff did not appear to have the time to spend with people to support them in the way they should.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people who used the service told us that they were offered choices about their daily preferences. One person told us: "I like to eat my dinner in my chair with the TV on, but they [Staff] still ask me if I I'd prefer to sit at the table just in case I change my mind". Another person told us: "I get up when I want, and staff always come and help me get ready in the mornings".

The new manager had arranged to meet with people and their relatives on a regular basis and had written to everyone to introduce themselves. Relatives we spoke with told us they were kept informed of their relative's welfare. One person told us: "I've never had a reason to complain, they do seem really busy at times but they do their best. Obviously, I'd rather be in my own home, but I'm not unhappy here".

Requires Improvement

Is the service responsive?

Our findings

Not everyone who used the service experienced care that met their individual preferences. Some people who were living with dementia were supported to get up in the morning and taken to the lounge; other people were cared for in bed. It was unclear from people's care records what these people's preferences were as most people were unable to tell us and we did not hear them being offered a choice of getting up or staying in bed or engaging in an activity. Some people sat all day with little or no interaction to stimulate their senses. Other people who were able to, participated in a flower arranging session in the garden area but this was only available to a limited number of people.

Several people told us there were routines which restricted what they were able to do and when. A relative told us: "There are set times when the staff help people to go to the toilet but my relative sometimes can't wait until then". A person who used the service told us: "It depends on what the staff have got on as to what time I can get up in the morning, today it was this afternoon as they were busy". One person told us they were unable to get up because there were not enough suitable chairs. We observed that within the nursing unit everyone was using the same lidded cup whether they required one or not. This meant that people's individual needs and preferences had not been recognised and respected.

We were informed that another person had fallen out of bed and following a meeting their relative had requested a bigger bed. They were told this would be arranged for them, however this had not happened several months later. Another person told us they wanted to get out of bed but there were not enough suitable chairs in the lounge so they had to remain in bed. This person's relative supported what the person told us by saying that people had to take turns and share the chairs in the lounge areas.

This meant that people's individual needs were not being recognised and responded to and this was a breach of Regulation 9 of The health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt that they were able to complain. A relative told us: "I'm very happy with everything, staff are all nice and friendly, we've had no complaints and I would report any problems straight to the senior in charge or the manager". Another relative said: "We've had no complaints, but if I did I would go straight to the manager to report it". The manager told us there had been no recent complaints.

Inadequate

Is the service well-led?

Our findings

The provider had not made the required improvements since our last inspection in July 2015. The systems the provider had in place to monitor and improve the quality of service had been ineffective. We found that at this inspection that there were now several breaches of Regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and people were receiving care that was not safe or effective.

People's care records were not audited and up dated to ensure they contained current information on people's needs. This meant that new and inexperienced staff did not always have access to the correct information within the care records to be able to care for people safely. This for example meant that one person had not had their prescribed medication when they needed it and matters that required addressing such as weight loss had not been noted and acted upon. This put people who used the service were at risk of ill health and poor care due to ineffective records.

The medication audit was ineffective. It had not been identified that medicines were running out of stock, the incorrect doses of prescribed medication being administered and the times when people were receiving their medication may not allow there to be sufficient time between doses. This put people's health at risk due to people not having their prescribed medicines at the times they needed it.

The provider had not identified that people who used the service were at risk due to there not being sufficient, suitably trained staff available to meet people's needs safely. Staff had been completing duties that they were not trained to do and there were insufficient staff deployed in certain areas of the service and this put people at risk. This put people at risk of poor and unsafe care due to their being insufficient staff.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager; however a new manager had been working at the service for a short time. The new manager had put together an action plan and had started to identify areas that required improvements such as the DoLS authorisations. They had set up support meetings for staff, people who used the service and their relatives. They had begun to gain feedback through quality surveys to identify areas that required improvement. Staff, people and their relatives told us the new manager was approachable and supportive.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care that met their individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not receive care that was safe and met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not safeguarded from abuse through neglect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People's nutritional needs were not always

met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The system the providers had in place to monitor and improve the quality of the service were ineffective.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient suitably trained staff to meet the needs of people who used the service safely.