Meridian Healthcare Limited

April Park Nursing Home

Inspection report

West Street
Eckington
Sheffield
Derbyshire
S21 4GA

Tel: 01246430683

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 5 May 2016 and was unannounced.

April Park Nursing Home provides a residential service to older people. It is registered for 40 people and at the time of the inspection there were 32 people living there. There was no registered manager in post. However, the new manager was in the process of applying for registration. 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.

Staff understood their responsibilities to care for people and keep them safe from harm. They knew how to recognise and report abuse or any concerns they may have regarding a person's safety. Staff were recruited using safe recruitment policies and all appropriate checks were completed before they started work ensuring they were safe to work with vulnerable adults. Medicines were managed safely and records and systems were audited to ensure safe practice was followed which reduced the risk of harm to people.

Risk assessments were not always completed thoroughly or reviewed in a timely manner. This meant that risks to people were not always identified or mitigated by appropriate risk management plans. On the day of our inspection possible risks to people due to the work being carried out had not been appropriately assessed.

Staff had access to a variety of training. They were supervised and observed by senior workers or managers and received constructive feedback on their practice and knowledge. However, we were concerned that the necessary authorisations had not always been sought to protect people who lacked capacity to make decisions about their care and treatment.

People were cared for by staff who enjoyed their work and developed relationships with people based on respect and dignity. Staff appeared to know people well and understood their personal needs and preferences. Support was offered in a discreet and timely way. However, when staff were busy they adopted a task-focused approach and did not have the same amount of time to spend with people on a one-to-one basis.

People and their families actively contributed to their initial assessments and care planning, however, we found little evidence of this continuing when care plans were reviewed. Staff were not always aware of people's previous lifestyles and interests. The provider had recently imposed a new menu, food list and supplier onto the service and there was no evidence of any consultation with people or their families.

The service was going through a period of change and staff were supportive of this. However, the process of improvement was not very clear and appeared to be disjointed, with no evidence of the involvement or

impact on people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks assessments associated with people's care were not always updated in a timely manner. Nor did they contain all relevant information available.

Staff understood how to report any concerns or risk of abuse in order to keep people safe.

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Authorisations for Deprivation of Liberty Safeguards were not always in place where they were required by law under the terms of the Mental Capacity Act 2005.

Staff had access to a variety of training that supported them to meet the needs of the people they cared for.

People enjoyed the food and were given a choice from a balanced and nutritious menu.

Is the service caring?

Requires Improvement

The service was not always caring.

Some staff did not fully understand the principles of person centred care.

Staff promoted the independence, privacy and dignity of people. However when busy, staff adopted a task focused approach, which was not always caring or person centred.

People were cared for by kind and friendly staff, who enjoyed their work.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The provider did not always consider the choices and preferences of the people using the service, when making changes.

Not all care plans contained "Life Story" information. This meant that staff did not always know people as well as they could and therefore could not always provide personalised care and support.

Is the service well-led?

Requires Improvement

The service was not always well led.

On the day of our inspection there was no registered manager in post. However there was an experienced manager in post who was in the process of registering with the Care Quality Commission.

There was a process of change and refurbishment within the service but there was no visible plan available. This made it difficult to for the manager to check progress against the plan and measure impact on people using the service.

Staff were supportive of the new manager and the changes taking place.

April Park Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 May 2016 and was unannounced. The inspection team consisted of an inspector, an inspection manager and a specialist professional advisor (SPA). The SPA was a recently retired nurse with experience of working with older people including those living with dementia.

To prepare for the inspection, we reviewed any information we held about this location including notifications sent to us by the provider and previous inspection reports. Notifications are incidents or events that providers must tell us about as part of their registration. We also contacted other agencies who worked in partnership with April Park and provided coordinated care and support to the people who lived there. This enabled us to take into account the views of other health practitioners who were familiar with the service.

During the inspection we spent time observing care and interactions between residents and staff. We spoke with six people who used the service, three relatives, two visiting health practitioners and six staff including the registered manager, regional operations manager, senior support worker, carers and cook. We reviewed care plans and associated care records. We also reviewed the recruitment records of four staff members, training records, minutes of meetings, policies and procedures, health and safety records and other records associated with the management of the organisation.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the service. One person told us, "Yes, I feel safe here, the staff are very good". Relatives told us they felt their family were safe at April Park, "Oh yes [relative] isn't neglected, they're very good with them".

Staff members told us that people were safe. Staff members told us that they received training on safeguarding adults and knew how to report concerns of abuse. They told us they understood the safeguarding reporting process and the whistle blowing process. We also viewed training records which confirmed that all staff had received safeguarding adults training and there were posters around the building that advertised the shared responsibility to safeguard adults and the whistleblowing hotline number. We had previously received reports of safeguarding concerns from the service and from whistle-blowers which meant that staff were aware of and followed these processes. This meant that staff were aware of the needs and risks to people and received the training necessary to report any concerns about abuse and protect people from harm.

Staff told us that risks relating to people's care were assessed and plans were developed to reduce the risk of harm to people. Care plans we viewed included risk assessments for people that used the service. However when we cross-referenced some of these with incident reports we found that risk assessments had not been always been updated and did not always include all the information available regarding incidents and risks to people. For example, when we reviewed the accident and incident files, we noted one incident where a person had absconded from the premises. At the time, staff did not realise until the person was returned by a local neighbour. The incident records showed that staff were not aware this person had absconded and did not investigate thoroughly when an alarm sounded and an external door was found open. The manager said this was the first time this person had done this and they now had a risk assessment in place.

However our inspection of records found evidence that this person was a known risk of absconsion and had previously attempted to leave the building on a daily basis. As it was not considered safe for this person to go out alone a DoLS had been in place for the past year. The manager said they were not aware of the absconsion risk.

On the day of our inspection there were workmen in the building replacing ceiling lights as part of a planned improvement programme. The workmen were observed removing and installing lights around people sitting in the lounge. This put people at risk of harm from falling debris and of distress or confusion, due to the general disruption. We discussed this with the manager and asked if a risk assessment in relation to this had been completed. They advised us no risk assessment had been completed but that people did not want to move to another room because, "They like it there". We were concerned that risks relating to the improvements works at the service had not been appropriately assessed.

We found that where signs and notices relating to the environment were in place to keep people safe, these

were not always being followed. For example store room doors upstairs were unlocked although each door had a sign on it, saying it must be locked at all times. We observed in a communal bathroom a large sign instructing staff to, "Turn the temperature down to cold when finished", yet the temperature gauge was left on hot. This could pose a risk of scalding to people or to staff assisting a person in the bath. When we discussed this with the manager they were unable to offer an explanation.

At the last fire safety inspection by Derbyshire Fire and Rescue Service (DFRS) in 2015, they identified some areas of concern regarding the fire doors and evacuation processes. DFRS had made some recommendations which the manager told us had been included in the improvement plan for the service. However, they told us some recommendations were still outstanding and they could not give a firm date for completion.

These examples demonstrated that safe working practices were not always followed by staff and the manager was not always aware of all of the risks to people using or visiting the service. Risk assessments did not always consider all the information or known risks to people which meant they were not as effective as they could have been and potentially placed people at risk of harm.

One staff member told us they felt there were enough staff on duty to, "Do all we need to do", and "There's always extra staff to call on if necessary – domestic staff, kitchen staff and managers; and people are willing to do extra where needed". The manager told us about the dependency tool they used to decide on staffing levels and this was flexible depending on the needs of people using the service. In response to feedback from staff the manager had recently introduced a 'twilight shift' (8pm – midnight) to provide additional support during the evening before people went to bed. Staff fed back to us that this had a, "Positive impact on people". However, during the afternoon we observed there were periods when no staff were available in the upstairs lounge when a person was confused and needed support and assistance. We were later told this was because the two staff upstairs were assisting someone else at the time. However, we felt this demonstrated that the staffing levels were not always sufficient to meet the needs of people or staff were not always deployed effectively to manage the individual needs of people.

We viewed four staff files to check that safe recruitment practice had been followed. All four files held completed application forms, two written references and copies of pre-employment checks. This meant that people employed in the service were safe and sufficiently experienced to provide effective care for people.

We observed that medicines were managed, stored and recorded safely. We saw records that showed they were also audited regularly. Staff who administered medicines told us they had been trained by a specialist external trainer and had internal competency assessments, which they told us, "Are very thorough". Records we saw confirmed training and competency assessments had taken place. Staff told us they were confident in their ability to administer medicines and as the manager was a nurse they would always ask for guidance if they were not sure. A relative told us, "[family member] gets everything they need". We observed a medicines round and were satisfied that all processes were safe and reduced the risk of medication errors which could have caused harm to people.

Requires Improvement

Is the service effective?

Our findings

One person told us, "Staff are very good, they know me, they know what to do with me". A relative told us, "The staff seem to know what they are doing, they really know my [relative]". Staff told us they received, "Lots of training" and training records that we saw confirmed this. The manager explained that the service used a combination of in-house, online and external training. They told us that training records were monitored to ensure that staff completed courses in a timely manner. This ensured that everyone was up-to-date with the expectations of the provider, current safe working practice and were trained to meet the individual needs of people using the service.

Staff told us they had supervision and used new supervision forms which provided an opportunity for both staff and supervisor to comment on progress and performance. This was considered a positive move by staff who said they would be, "More involved" in the supervision process. This showed that staff were supported and developed by the systems in place. They were involved in the supervision process and it provided opportunities for constructive feedback on their practice.

Staff members explained the handover process that was in place and how information was shared between staff which enabled them to be aware of the changing needs of people. The manager had also introduced a 'resident of the day' system where one person's records were audited and updated with the new paperwork, each day. This gave staff opportunities to familiarise themselves with the new processes, and with individual people as information was reviewed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Staff had an awareness of MCA and the needs and risks of people who lacked the capacity to make decisions regarding their safety, care and treatment. Staff told us they had been involved in making 'best interest decisions' in the past with people who lacked capacity which included the involvement of family members and health practitioners; records we viewed confirmed this. This showed that the thoughts, wishes and preferences of people who lacked capacity were considered when making 'best interest decisions' about their care and treatment.

The manager, who had been in post for four months was not fully aware of which people had DoLS in place and was waiting for confirmation of this information from the local authority. Therefore this would make it difficult for them to fully assess the risks to people and ensure appropriate risk management plans were in place that met the requirements of the MCA. It also meant that some people could have been subjected to

unauthorised restraint, as they were prevented from leaving the building, without a DoLS in place.

People told us they enjoyed the food at April Park and they had a choice of different options. One person told us, "Oh yes, I like the food. I like chicken, turkey and sausages, oh and shepherd's pie. I don't like beef – staff know what I like". Another said, "The food is OK, I just don't feel hungry today, but I do like the puddings". The cook and staff were aware of the likes, dislikes and any allergies of people and were able to offer choices that met people's preferences. Staff told us they knew where people required supplements with their diet or needed their hydration monitored, in order to maintain their health. Records we saw confirmed monitoring was taking place where it was appropriate to do so.

We spoke with a visiting district nurse and a chiropodist who told us they had a good working relationship with the service. Both made regular and frequent visits to people living at the service to ensure their continued health and remarked on how things had improved since the new manager was in post. One visiting healthcare professional said, "Things have definitely improved here since the new manager has been here. I visit several homes and this is the best one". Staff told us they worked closely with external health agencies to promote the health of people living at the service and they have quick access to the local pharmacy and GP for urgent referrals or advice. We saw records of external health professional visits and where staff had updated care records with relevant information regarding health checks and outcomes of visits from other healthcare professionals. This demonstrated that people were supported to access healthcare services that met their varied needs.

Requires Improvement

Is the service caring?

Our findings

One person told us, "Staff are very good, they know me. They know how to get me out of my moods if I'm having a bad day – I like it here". Another said, "The staff are not bad, can't complain, some better than others but they do look after you". A relative told us staff were, "Very caring and supportive – we can't fault them" and "[my relative] has everything they want".

A staff member told us, "I love working here, everyone gets on so well and I love being with the residents". Another staff member said, "I love my job. Some residents have been here for a while and we know them well – they're like one of the family".

Staff said they had time to talk to people and, "We all care about people, that's why we're here". We observed interactions between staff and people living at the home, which appeared natural and caring. This showed that people were able to develop relationships and friendships with staff based on respect.

We saw from care plans that people and their families were involved in initial assessments and care planning, and people confirmed this to us. We also saw evidence in files of people and families being involved in 'best interest decisions'. However, there was little evidence that people or families were involved when care plans were reviewed or when there were changes in the care needs of people. This meant that peoples involvement in their care and treatment was inconsistent and their choices and independence was not always considered.

People were able to choose where they spent their time, either in one of the four communal rooms or in their own rooms. People's rooms included extra seating for visitors. This showed that people were able to have privacy when they had visitors.

People were treated with kindness and respect and were approached in a professional and caring manner when they were distressed or needed attention. Staff told us they understood how to promote people's dignity and privacy and we observed examples of discrete support during the day.

However, during the busy lunchtime period, we observed some people did not receive the support and encouragement they appeared to need for them to eat their meal with dignity and whilst it was still hot. We observed one person who appeared to be having difficulty eating their meal with dignity and would have benefited from the use of plate guards to enable them to eat independently. However, these were not in use. We also saw some people had their meals removed without comment, even though they had barely eaten it. This demonstrated that although staff were kind and caring when they had time to respond to the needs of people, they became more task focused when time was limited or they were busy. This meant that there were occasions when staff did not promote the dignity of people.

Requires Improvement

Is the service responsive?

Our findings

One person told us, "I enjoy bingo, but they don't do it enough, they're always too busy. I like to play dominos but there's no-one to play with any more". The manager explained that they were recruiting new staff and with the addition of an activities co-ordinator and a 'twilight shift' (from 8pm – midnight) they were planning to increase the number and variety of activities for people. The activities worker explained that they provided group activities along with individual activities for people who were unable or preferred not to join in group activities. They told us where possible they aimed to offer activities which supported people's interests; however they also liked to introduce new activities to people and offer variety and an "opportunity to try something a bit different".

On the afternoon of our visit we observed a reminiscence activity taking place which people appeared to enjoy as they were laughing and chatting with each other. We saw notices promoting planned activities that took place on a weekly basis. These included chair based exercises, entertainers and local walks. On the day of the inspection visit one person was taken out in the new minibus for a drive and a short walk around the park, as this is what they had requested to do. Staff told us the arrival of the new mini-bus enabled them to do, "Far more things with people now. We can take them wherever they want to go and give them a change of scenery". This showed that where people's interests were known by staff they provided activities for people to enjoy and spend time with each other.

Whilst people and families contributed to the initial planning of their care but there was little evidence of any further involvement once people had moved into the service. There was limited information in people's files about their personal history and past lives. Although the manager had introduced "My Life Story" paperwork into people's files, these had not all been completed at the time of our inspection and therefore could not be used to develop an understanding of a person's particular interests or preferences. The manager said, "Staff are still getting to grips with all the changes and it will take time". This meant that it was not always possible for staff to provoke an interest in activities taking place, or to provide activities of personal interest.

The provider had recently imposed a new menu, food list and supplier on the service which meant that all menus had changed and some items of food had been removed from the menu. There was no evidence to show that people had been consulted about the change in food options and staff told us one person had complained as their favourite cake was no longer available. The manager was quick to respond and sought permission from the corporate provider to buy this locally, which was agreed. However, they told us they were no longer able to provide sausage rolls and pork pies, as it was not possible to, "Trace their origins". When asked if families could bring in food for residents if it was not provided by the home; the manager said, "Yes, but we have to inform them that it is a 'risky food' and we cannot be accountable if their relative becomes ill after eating it". This showed a lack of respect and consideration for the personal preferences and choices of people and a risk-averse attitude to inclusive decision making.

The manager told us that families were encouraged to provide feedback to the provider each year and there

was evidence of this on the day of our inspection visit, with posters and questionnaires available. The manager told us they held monthly meetings for relatives, when they could feedback on the service and discuss any concerns or service updates. However, we could not find any reference to the dates of the planned improvements in the minutes of these meetings; so people were not aware of the actual dates when workmen would be at the service. Relatives we spoke with told us that they were unable to attend the meetings due to work commitments, and they had not received minutes from any meetings so were unaware of what had been discussed. This meant that the service had not ensured that people were appropriately consulted or informed about changes at the service in an inclusive and meaningful way.

One person explained how they had been moved to a different room when they were not happy with the room they were in. People and families told us they were confident to complain to the manager if they were not happy with anything. There were copies of the complaints policy available in rooms and on notice boards so people were aware of the process for making complaints.

However, when we reviewed the management records it was apparent that not all complaints had been recorded within the complaints record. For example there was a complaint discussed in team meetings that had not been recorded on the complaint record. There were also comments made in relatives meetings that had not been followed up as complaints. This meant the manager did not have a clear picture of all complaints received and any responses or learning from investigations that had been carried out. This made it difficult for them to complete accurate audits and demonstrate how they had listened to suggestions from people to improve the service. They could also not be assured that people's complaints had been appropriately investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post at the time of our inspection visit. The new manager was going through the process of registering with the Care Quality Commission (CQC) to become the registered manager. However, we were satisfied that the service was being 'managed' by the arrangements in place and the manager was being supported by the senior management in the wider organisation.

Relatives told us, "[manager] is great; she keeps me informed about [my relative]. She's been in today to see [my relative] whilst I've been here". Another said, "[manager] understands what we want and what's best for [relative]". This demonstrated that the manager was a visible presence in the service and was approachable.

The manager recognised that the staff team were going through a process of change and readjustment at the point of our inspection visit. However, staff told us they were supportive of the changes made and spoke of the benefits for people using the service and for themselves as a team. One person said, "[manager] is lovely, she's moving things on". Another said, "I like it here; the manager has some good ideas and supports me developing my skills"; and another said, "[the manager] is alright, not been here long, she's firm but fair, gets her point across. She's taken the pressure off us, especially with the new deputy manager role, now I'm more hands on"; and "The files are easier to evaluate, she's simplified them". This demonstrated that the manager promoted a positive and empowering culture within the service.

The manager explained how they had introduced daily 'walk-rounds' and 'flash-meetings' which enabled them to share information quickly, observe staff practice and do environmental checks. Staff told us they appreciated this, as the manager was more visible to them and the people living at the home. They said they felt actively involved in developing the service and received regular feedback from managers in a constructive and motivating way. This meant they felt supported and valued by the organisation.

The manager said they used quality assurance systems to monitor and improve the quality of the service; and were 'working their way through the improvement plan'. When asked for a copy of the improvement plan, the manager was not able to provide one. However they did provide copies of the fire risk assessment and 'home visit' quality assurance records (carried out by the provider) which identified areas for improvement. As these actions were not transferred onto a service improvement plan it was not possible for us to see the overall picture. The process of improvement was not clear and appeared to be disjointed, which made it difficult for the manager to check progress and consult with people in a timely manner. As there was no formal review of the changes, there was no way the manager could assess whether the changes had had a positive impact on people using the service. There was also no evidence to demonstrate that people had been involved or consulted about the changes being made.

The manager said all incidents and reportable events were notified to the CQC. However, our inspection of the accident and incident records found some incidents had not been notified to us. We also noted some incidents had not been thoroughly investigated and lacked evidence of outcomes, changes to risk management plans and learning applied to prevent a future occurrence. This meant that the quality assurance systems in place were not robust enough to identify all areas for development and measure the

impact on people using the service.