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Frenchay Park Gardens Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Frenchay Park Gardens is a care home. People in care homes receive accommodation and nursing 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. Frenchay Park Gardens provides accommodation with nursing and personal care for up to 30 people. At the time of our inspection 18 people were living in the home.

At the last inspection in October 2015, the service was rated Good. We carried out a comprehensive inspection on 23 January 2018. At this inspection we found, overall, the service remained Good.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Sufficient numbers of staff were deployed at the time of our visit. Staff performance was effectively monitored. Staff received supervision and training to ensure they could meet people's needs.

People's medicines were managed safely and audits and checks were completed. Actions were taken when errors were identified.

Staff demonstrated a good understanding of safeguarding and whistleblowing and knew how to report concerns.

Risk assessments and risk management plans were in place. Improvements were needed to make sure risk management plans were followed. We have made a recommendation that further guidance is sought with regard to infection control practices in the home.

Incidents and accidents were recorded and the records showed that actions were taken to minimise the risk of recurrences.

People's dietary requirements and preferences were recorded and people were provided with choices at mealtimes.

Staff were kind and caring. We found people were being treated with dignity and respect and people's privacy was maintained.

Systems were in place for monitoring quality and safety and actions were taken where areas for improvement and shortfalls had been identified.

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 to people's safety were not always managed. Improvements were needed to minimise the risk of the spread of infection and to make sure risk management plans were consistently followed.

Medicines were safely managed and people were supported to take medicines when they needed them.

Accidents and incidents were reported, recorded and actions taken to minimise future risks.

Staff were safely recruited and sufficient staff were deployed to meet people's needs.

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 service remains good.

Frenchay Park Gardens Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a comprehensive inspection of Frenchay Park Gardens Care Home on 23 January 2018. This involved inspecting the service against all five of the questions we ask about services: is the service safe, effective, caring, responsive and well-led.

The inspection was unannounced. This meant the staff and the provider did not know we would be visiting. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit we looked at the information we had received about the home. The provided had completed a Provider Information Return (PIR). This is a form that asks the provider for key information about the service, what the service does well and the improvements they plan to make. We also looked at the notifications we had received. Notifications are information about important events which the provider is required to tell us about by law.

During our visit we spoke with 12 people who lived at the home and two relatives. We spent time with people in their bedrooms and in communal areas. We observed the way staff interacted and engaged with people.

We spoke with the area manager, the trainer, the registered manager and nine staff that included a registered nurse, care staff, maintenance, housekeeping, laundry, activity and catering staff. We spoke with a visiting health professional. We observed medicines being given to people and how equipment, such as pressure relieving equipment and hoists, was being used in the home.

We looked at five people's care records. We looked at medicine records, staff recruitment files, staff training records, quality assurance audits and action plans, records of meetings with staff and people who used the service, complaints records and other records relating to the monitoring and management of the home.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were completed, for example, in relation to moving and handling, eating and drinking, skin condition and development of pressure ulcers and falls. Risk management plans were in place where risks had been identified. Assessments were reviewed and updated on a regular basis and when there were changes. However, we found risk management plans were not always followed.

We noted three people had been assessed as at high risk of developing pressure ulcers, or already had skin damage. They had management plans that included the provision of pressure relieving mattresses. The registered manager had introduced a system to check pressure mattress settings on a daily basis. We found the settings incorrect for the three people we checked, although records had been completed that stated the settings had been checked and were correct. This meant people may not have received the pressure relief they needed, and were therefore at risk of their skin condition deteriorating.

We also noted where people were recorded as needing support to reposition on a two to four hourly basis, monitoring records were not always completed to confirm this had been completed. We brought the above noted shortfalls to the attention of the registered manager on the day. They took immediate action to address the shortfalls and confirmed this in writing to us the following day.

People and relatives told us they felt safe in the home. Comments included, "I do feel safe here" "I feel safe and I feel like the other (people living in the home) are safe too," and, "On the whole I would say yes." A relative said, "This place is fantastic. They are attentive and make sure she is safe at all times."

Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people, including how to report any concerns. Information was readily available for staff that included local authority contact details which were displayed on the notice board in the staff room. Staff told us how they made sure people were not discriminated against and treated fairly.

Accidents and incidents were recorded and actions taken to reduce future risks of injury. For example, one person had fallen out of bed and sustained an injury. Actions were taken, medical advice was sought and the person's care plan was reviewed. They were provided with an 'ultra-low' bed to reduce their risk of future injury. This meant that patterns or trends were identified and actions taken where needed.

Most of the people we spoke with told us staffing was sufficient. They told us staff responded to calls for help and support in a timely manner. One person commented, "I think an extra one wouldn't hurt, but I don't think it has ever been low enough to the point where it's unsafe." The staff we spoke with told us that on most occasions staffing was sufficient. They told us they sometimes 'struggled' in the afternoon and evening when there was one registered nurse and two care staff on duty. The registered manager told us they were planning to increase the staffing and were appointing catering staff to work in the kitchen during the afternoon and provide support during the evening meal time.

People had access to call bells and during the day of our visit calls for support were promptly responded to. The registered manager told us they didn't use a formal dependency assessment tool to calculate the staffing needs in the home. They told us they spent a lot of time talking with staff, people who used the service and relatives to obtain views about staffing. We saw the registered manager regularly walked around the home and was visible and accessible to everyone during our visit.

Staff files included application forms, proof of identity, interview notes and references. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS check ensures that people barred from working with certain groups such as vulnerable adults are identified. Additional checks were completed to make sure registered nurses had current registration with their regulatory body, the Nursing and Midwifery Council.

Overall, people received their medicines safely. We observed people being given their medicines. The registered nurse followed good infection control practices, spoke to people respectfully and gave people time to take their medicines. There were photographs at the front of medicine administration record (MAR) sheets which meant people could be easily identified. People's preferences for how they took their medicines were recorded in a section entitled, 'Medicine record Client Profile'.

MAR sheets were checked each day to ensure medicines had been signed for and coded appropriately for non-administration. We saw no gaps in the charts we looked at which indicated that people received their medicines as prescribed. Where people had medicines and creams prescribed as required (PRN), protocols were not fully in place. Forms were provided, but these had not always been completed to describe the circumstances in which people may need these medicines. We brought this to the attention of the registered manager who confirmed after our visit, that forms had all been completed and protocols were fully in place.

Medicines were safely stored. Arrangements were in place for medicines that required cool storage and those that required additional security. There was a system for recording the receipt and disposal of medicines so that staff knew what medicines were in the home at any one time. This helped to ensure that any discrepancies were identified and rectified quickly.

Most of the records we saw were safely and securely stored. However, a desk in the dining room which we were told was used, 'by the nurses for writing up notes and making telephone calls' contained information about people that was not secure and confidentially stored. For example, we saw a hospital appointment letter for one person that was open on the desk. We brought this to the attention of a senior member of staff who removed the letter and told us they would make sure staff were made aware of the importance of making sure all such information was securely stored.

Premises safety checks had been completed for water temperatures, legionella control, electrical and gas safety, lift maintenance and hoist checks. Routine weekly and monthly fire safety measures and checks were in place. The home had undergone a significant period of refurbishment and the home had closed for a period of time before reopening in January 2017. Further building extension works were being undertaken, outside of the home, and temporary fire evacuation measures had been introduced. Two designated empty bedrooms were being used as emergency exit routes. A fire risk assessment review had been completed in December 2017 and the contractor wrote to the provider after out visit with their findings and recommendations.

Personal emergency evacuation plans were in place. They provided guidance about how people could be moved in an emergency situation if evacuation of the building was required.

The environment was clean and staff were able to tell us about cleaning routines. We observed staff using gloves and aprons when needed which showed good infection control practices. The laundry area however, was not safely managed. It did not provide separate areas for clean and soiled linen. This is required to comply with current health and safety guidance. Following our visit, the registered manager sent us an updated management plan. This still confirmed the risk of contamination and infection spread remained high. A representative for the provider has since confirmed their plans to provide additional laundry facilities as part of the building extension works.

A communal toilet was used for storage of soiled items for disposal. There was no sluice or dedicated 'dirty utility' area provided. Following our visit the registered manager completed and sent us copy of a 'Protocol for disposal of soiled items, dressings, and cleaning of commodes, bedpans and urinals'. The provider confirmed in their PIR that a sluice was being provided as part of the building extension and upgrade works.

We recommend the provider seeks guidance from Department of Health to ensure their infection control practices and protocols are maintained in line with current best practice and national guidance.

Good

Is the service effective?

Our findings

People received effective care from staff who had received training and support to carry out their roles. Staff told us they felt well supported by colleagues, the trainer and the registered manager. One member of staff commented, "The training is all recorded on a matrix and [Name of registered manager] or [Name of area trainer] follow up and make sure we're up to date"

When new staff started in post they completed an induction programme and then shadowed colleagues to gain practical experience. The induction programme incorporated the care certificate, a national training process introduced in April 2015. This was designed to ensure staff were suitably trained to provide a basic standard of care and support.

Staff told us they had regular supervision meetings and the registered manager told us they aimed to complete three supervisions each year in addition to each member of staff receiving an annual appraisal. The training records showed that staff were provided with regular update and refresher training for topics such as fire safety, moving and handling, safeguarding, mental capacity act, infection control and food safety. In addition registered nurses were provided with updates that recently included venepuncture and falls management training. Information packs were available to provide additional illness specific information for staff.

People were supported with food and fluids and we saw most nutritional needs were being met. The people and relatives we spoke with were positive about the food and feedback included, "Plenty of choice" "Lots of variety" and, "Anything you want really." We observed meal service to people in the dining room and to people who stayed in their rooms.

Most people chose their meals in advance of meal service. The catering staff told us people could change their minds and they would be provided with alternatives. They were able to tell us about most people's' likes, dislikes and if they had any specific needs. However, we spoke with one person who was not informed of the type of meat being served on the day of our visit. This meant that what they were served was not acceptable for their needs. The registered manager took immediate action to make sure the person's individual needs, going forward, were clearly known, recorded and communicated.

Care plans contained nutritional assessments and people's weights were monitored. When people had lost weight, support and advice was sought in a timely manner. People were referred to the GP and prescribed supplements if needed. The records for two people who had been assessed as at high risk of malnutrition and needed support with their food and fluids, showed the support they were being given. Their weight had remained stable during the year leading up to our visit.

People had access and were referred to external health professionals. The records showed that people had been visited by a range of health professionals that included GP's, nurse practitioners and social workers. A visiting health professional spoke positively about the service provided and told us staff responded promptly to changing needs and made appropriate and timely referrals. They told us the registered

manager was, "Really on the ball. Knows when to contact us and responds well to advice and guidance."

A relative told us they had been updated with phone calls when there were changes. They told us communication was good and they "Had a couple of phone calls so far to keep me in the loop."

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.

Consent to care and treatment was generally sought in line with legislation and guidance. Most people told us that staff asked before they provided care and support. Comments included, "The majority do but one or two don't" and, "Yes they do." Two people commented that some staff did not always ask and as one person said, "It's mixed, some just want to be done with you."

When people lacked capacity to consent, best interest decisions were made in consultation with relevant others, such as relatives or GP's. Staff we spoke with told us how some people declined care on occasions and one member of staff said, "[Name of person] is very receptive if you are quiet and gentle. If she doesn't want you to help, you just go back and try later."

People who lack capacity can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

We found that the service had submitted DoLS applications for people, and we looked at the records for one person with a current DoLS in place. The care plan provided guidance for staff to 'leave her safely and then return later.'

Good

Is the service caring?

Our findings

We received positive comments and feedback from people using the service and from relatives. People told us they felt respected and that staff were considerate and kind. Comments included, "Lovely they are to me," "Very caring," and, "I am very happy here, I would move if I wasn't. I'm always given a choice of what I want to do and I'm in control." A relative said, "So caring, they are very attentive. It's obvious to me that they care."

Everyone living in the home that we spoke with, was able to make their needs understood verbally, albeit for some people, prompting and encouragement was needed. We spoke with staff who told us some people needed, 'Just a little bit more time' to express their needs. A member of staff told us how they supported one person by helping them with prompts for words they found difficult.

People were encouraged to be as independent as possible. However, staff also recognised and responded when people were not feeling well, or had days when they were less independent. For example, one person was distressed at times during the day of our visit. We spoke with staff who told us the person, "Often has days like this" and on such days needed more support from staff to help them to stand and move. The person was sensitively supported and encouraged whilst staff recognised the person was not so well that day. Another person usually spent their day in their chair or in the lounge. On the day of our visit they had chosen to stay in bed, and their right to make this choice was respected.

We saw other people had chosen to stay in their rooms during the day. Staff popped in from time to time to provide drinks or meals and on occasions, as one member of staff was heard to say, "Just checking you're ok and if you want anything." People also told us that drinks were made readily available during the night if needed or requested. One person commented it was not a problem because, "Staff check on me so regularly I don't really have to think about it."

Throughout the day of our visit we observed staff talking with, and providing support for people using the service. There was an evident rapport and people clearly enjoyed the company of the staff supporting them. There were lots of smiles and friendly banter. It was clear from the conversations we heard that staff knew people well.

Staff knew and understood people's preferences for the gender of care staff who supported them. This was also recorded in the staff handover records.

Staff explained how they made sure people were treated with kindness and respect, and how privacy and dignity were maintained. Comments from staff included, "I think we give really good care here. We know people well and their little ways, so we do more than the basics of making sure curtains and doors are closed when we are giving care" and, "You can see people have been well cared for. [Name of registered manager] keeps an eye and soon tells us if we've missed anything."

Visitors were greeted and welcomed by staff. One person told us, "Anytime of the day they can come in" and

another person commented, "Yes, they are made very welcome."

The registered manager told us in their PIR they had a, 'Zero tolerance of poor care as attitude and compassion are considered the core of delivering person centred care.'

We read recent compliment cards and letters received in the home. Extracts included the following, 'The last two months have been very difficult for all the family and we are grateful for the care and kindness you and your staff have shown to Mum. Your care has certainly made things a lot easier for us.' and, 'In the short time she was with you I think she enjoyed being there. In her words it was like staying in a 10 star hotel. Everyone has been very welcoming to all of us and her many visitors.'

Good

Is the service responsive?

Our findings

Before new people moved into the home they were assessed by the registered manager to make sure their care needs were known. Care plans were designed to reflect individual needs, choices and preferences in 'person centred assessment' records. They included details of people's physical, mental, emotional and social needs. These included eating and drinking, sleeping, breathing, personal hygiene, pain, distress reactions, expressing needs, spiritual fulfilment, motivation and relating to others.

We spoke with one person who told us they received support when they needed it. They told us, for example, they like to go to bed at 11pm. This was reflected in their care plan that also stated they could, 'Fully communicate her needs and emotions' 'Sleeps well and goes to bed at 11pm' 'Is able to state when in pain' and, 'Able to walk short distances with zimmer.' Another person told us, "The manager is very good. She knows how to treat people. She always makes it clear I can make my own decisions about things."

Care records were checked to make sure they were up to date each month. Care plans were formally reviewed every three months with involvement of people and their relatives to check they were still current and to make changes if needed. The staff we spoke with were able to describe the individual needs of people they cared for. They knew people's likes, dislikes and preferences. One member of staff told us, "I think this is a good place for people to live. We get to know the residents really well."

The registered manager had introduced 'sunshine days.' These were days when a person was the 'focus' of attention and visited by each head of department to make sure their needs and wishes were being met. For example, the chef was expected to check the person's dietary needs were being met, and ask if the person had any special requirements or requests. We noted occasions where the person had not been visited by a member of the catering team. The registered nurse checked and reviewed the person's care plan to make sure the plan was up to date and accurate. Overall, we found further developments were needed to fully embed sunshine days into the home.

We saw activities were provided. The weekly programme included bingo, afternoon film shows, flexercise classes, arts and crafts and quizzes. On the day of our visit, a group of toddlers visited with their parents and sang songs and nursey rhymes. The people in the lounge enjoyed the singing and one person said, "It's so nice to see the little ones here." Most of the people we spoke with told us they would like the opportunity to participate in more activities, with comments including, "We do really nice things, I wish there was more of it," and, "Not enough, I am bored a lot of the time."

People were provided with one to one support in their rooms. The activity staff told us they provided people with support of their choosing. They told us sometimes people just liked the opportunity to chat and so that is what they did. The registered manager told us they provided 'one to one time or activity with [name of registered manager].' This included supporting people with personal shopping, assistance with personal correspondence and reading letters and papers.

A complaints procedure was in place that was readily available to people and relatives. We looked at the

complaints file and saw that complaints were managed in accordance with the provider's policy. The registered manager took opportunities to make improvements and make sure lessons were learned. For example, staff were asked to write reflective practice accounts following one complaint and had looked at what they could have done differently and what they would do to make improvements in the future.

Good

Is the service well-led?

Our findings

Everyone spoke positively about the management arrangements and knew who the registered manager was. Feedback included, "Very approachable" "Lovely woman" and, "I often talk to her."

People's views and those of their relatives were sought as part of the quality assurance process to make improvements to the service. There were a variety of ways in which they could give feedback. These included annual surveys, residents' and relatives' meetings, care reviews and through the complaints process. People we spoke with told us that meetings were not well attended, with one person commenting, "Only three of us turn up most of the time."

Systems were in place that identified shortfalls, and audit and monitoring checks were completed by the registered manager and the representative for the provider. These included health and safety, meal service, medicines and care plan audits. Actions were taken when shortfalls or areas for improvement were identified. For example, it was noted that improvements were needed at mealtimes to make sure people were given sufficient choices. This was communicated to staff and recorded in the minutes of a staff meeting. In addition, 'near misses' were recorded and reflected upon, to enable improvements to be made. For example, a recent change was made to the ordering process when there were changes to dosages of medicine. This was to minimise the risks of an actual error or mistake occurring.

We found further improvements were needed to make sure shortfalls, such as those we reported on in the safe section of this report, were identified and acted upon. However, when brought to the attention of the registered manager, they took immediate action to minimise the risks and initiated a plan to address the shortfalls in the laundry and the arrangements for the disposal of soiled items.

Staff told us that Frenchay Park Gardens was a good place to work. They knew and understood the values of the organisation. Staff had the opportunity to express their views at general staff meetings and minutes were recorded and circulated. Staff told us they felt able to express their views and felt listened to. A member of staff commented, "We can speak to [name of registered manager] and she's always around." Another member of staff said, "This is an excellent place to work, we are so well supported, I don't think some staff realise just how good it is." We asked staff if they would recommend the home to others and we were told they would, with a member of staff telling us, "Yes, I think it would be good enough for my relatives."

The registered manager was able to tell us how they kept up to date with current practice. They told us they were provided with information and guidance from the provider. They also attended meetings with the provider's other local care home managers, local provider forums, and locally organised NHS workshops. For example, the registered manager attended a recent workshop to discuss how improvements could be made to 'out of hours care' and to treatment escalation plans (TEPs), which are plans that confirm end of life and resuscitation arrangements for people. The registered manager told us such meetings were useful and helped to make sure improvements were made for people living in care homes.

The registered manager told us about the building extension works that were being completed. Since our

last visit, upgrading and refurbishment works had been completed. At this visit, further building works were being undertaken and an extension was being built. The works were due for completion in June 2018. The provider told us in their PIR, 'All present and new rooms will have an ensuite to prevent cross infection' and, 'A treatment room will be in situ and a sluice.'

The registered manager was aware of their obligations in relation to the notifications they needed to send to the Commission by law. Information we held about the service demonstrated that notifications had been sent when required.