Four Seasons (Evedale) Limited

Park Lane

Inspection report

Park Lane
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 September 2016 and was unannounced. The last inspection was carried out in October 2013 and it was compliant in the areas inspected. Park Lane is a nursing home for up to 48 people who have support needs. There were 43 people living there at the time of the inspection.

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

The principles of the MCA 2005 had not always been followed. Checking relatives and representatives had the legal authority to make decisions on behalf of someone who lacked capacity had not always been completed. This meant that the service was not acting in accordance with the MCA to ensure that people's legal and human rights were respected and upheld.

The service was safe as people were protected from harm by staff who knew what constituted abuse and understood their responsibilities to report incidents of suspected abuse.
There were plans in place to support staff to help people manage their needs and risk assessments in place to keep people safe.

Medicines were managed safely and were administered as prescribed.

There were enough staff to cater for people's current needs and people did not have to wait for support. Staff had also been recruited safely to check they were suitable to work with the people who use the service.

People were supported to make choices where possible and staff supported people to do this.

Staff had sufficient training to support people in the home. Staff had supervisions and felt supported by the registered manager and management team.

People's nutritional needs were met and they told us they liked the food and there was a selection of food people could choose from.

People had access to a range of health services in order to keep them healthy and the staff made appropriate referrals when it was necessary.

Staff were caring and knew people who lived there well. People, relatives and staff were able to build relationships and people were treated with dignity and respect. People's privacy was respected.

Support plans and risk assessments were regularly reviewed and both people and relatives were consulted

about their care.

People had a choice of interests and hobbies they could be involved in, should they choose to.

There was a complaints policy available for people to access and people knew how to make a complaint and were confident their concerns would be dealt with.

Medicine and other audits were carried out regularly and action taken when an issue had been identified.

People, relatives and staff had confidence in the management team and found the registered manager 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?

Good

The service was safe.

People were protected from harm by staff that were aware of different types of abuse and how to report concerns.

Risk assessments were in place and were effective.

There were sufficient staff to support peoples' needs.

Safe recruitment practices were followed to ensure appropriate staff were working with people.

Peoples' medicines were safely managed and people had their medicine as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the Mental Capacity Act 2005 were not consistently being followed for people who did not have capacity to consent as some relatives were signing to consent on their behalf, without evidence of their legal authority to do so.

Peoples' where offered choices and staff supported people to make choices where possible.

Staff had been trained to support people effectively. Staff felt supported by the registered manager.

People had adequate amounts of food and their preferences were catered for.

People had access to health care services.

Is the service caring?

Good

The service was caring.

Staff knew people well and supported people in a caring manner.

Peoples' views were sought and taken into account in their care.

Privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People had their needs assessed and regularly reviewed.

People were supported to be involved with interests and hobbies of their choice.

The service had a complaints policy, and people knew how to complain.

Is the service well-led?

Good

The service was well-led.

Audits the provider had in place were effective in monitoring and improving the quality of the service.

A registered manager was in post who knew the people well.

Staff felt supported by the manager and had confidence in them.

Park Lane

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 was 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 September and was unannounced. The inspection was carried out by two inspectors.

We looked at information we held about the service including statutory notifications submitted. Statutory notifications include information about important events which the provider is required to send us by law. We also spoke to commissioners and Healthwatch to gain information about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and the other information we held about the service.

We spoke with seven people who use the service, four relatives, three members of staff that supported people and one visiting professional that had contact with the people who use the service. We also made observations in communal areas. We reviewed the care plans and other care records (such as medication records) for four people who use the service and looked at management records such as quality audits. We looked at recruitment files and training records for five members of staff.

Good

Is the service safe?

Our findings

People felt safe living at the home. One person we spoke with told us, "Staff make me feel safe because they make sure I use my frame to walk with". Another person told us, "I always feel safe with them using a stand aid". A relative we spoke with also told us, "My [relative's name] has their risks managed – they always have two members of staff with them to move". This meant people were supported by staff who could move them in a safe way and people felt safe when they were being supported.

The service had risk assessments in place in order to minimise the risks for people. For people who needed support to mobilise and walk around, there were support plans in place and risk assessments to help staff in supporting people and we observed staff assisting people to move safely. One relative we spoke with told us, "The number of falls [relative] has had has reduced dramatically since they moved here". Some people were at risk of skin breakdown and there were plans in place for staff to follow to help reduce the likelihood of a wound developing or worsening, such as monitoring the area closely, using the correct equipment and moving a person so they were not sitting or lying in one position for a long period of time. A relative we spoke with said, "The pressure area cleared up – [relative's name] had equipment to support them". We saw evidence of staff following these risk assessments and documentary evidence that skin areas had been monitored closely. This meant people were being protected from identified risks and risks minimised in order to keep people safe.

When people had accidents or incidents these were recorded, action taken was documented and monitored to look for developing trends. When there had been accident, we saw that the home had sought involvement from relevant medical professionals and the action documented. We saw evidence of accidents and incidents and their details being documented on a monthly basis with the day, time and circumstances recorded so trends could be identified. This meant people were protected from the likelihood of incidents occurring again.

People were protected against the risks of potential abuse. Staff we spoke with were able to tell us about the different types of abuse and the action they would take if they suspected someone was being abused. Staff told us they had received training to extend their knowledge about safeguarding. Staff also told us they knew where to find a copy of the safeguarding policy and the whistleblowing policy. This meant people were protected as people were supported by staff who knew and understood their responsibilities regarding safeguarding people.

We saw there were fire risk assessments and people had a personal evacuation plan in place, which identified the level of support they required should they need to be evacuated from the building. Other relevant checks were completed such as fire alarm tests, water hygiene and electrical safety checks. This meant that people were protected in the event of an emergency occurring in the home.

There were sufficient staff to meet people's care needs. People and relatives we spoke with told us they felt there were enough staff. One person we spoke with said, "I feel that there is enough staff, I don't have to wait". A relative we spoke with told us, "[Relative's name] is safe, there are always staff available" and, "You

can tell when staff are overstretched but it's not like that here, the atmosphere is different". Another relative we spoke to said, "I feel there is enough staff". We saw that there were enough staff, for instance at lunchtime people ate at the same time and did not have to wait for support or wait for their food.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure staff were suitable to work with people. Records seen confirmed that staff members were entitled to work in the UK as their identity had been checked. Nurses have to be registered with the Nursing and Midwifery Council in the UK and receive a pin number which confirms their right to work as a nurse. The registered manager had checked that nurses working within the home were all correctly registered and had the right to work as a nurse. This meant the service was checking that staff were suitable to work with people who needed support.

Peoples' medicines were managed and administered safely. The Medication Administration Records (MARs) which document when medicines have or haven't been given by staff had been completed and if a medicine had not been given, explanations had been documented and the medicine that needed to be destroyed had also been documented. If someone had medicine that was to be taken 'as and when required' (PRN medicine) then protocols were in place to help staff identify when a person required the medicine. The home also used Controlled Drugs which had been prescribed for people. Controlled Drugs are those which have extra regulations in place to keep people safe. Medicines were stored in an appropriate and secure location to keep people safe and the documentation was in line with guidance. Staff felt they had enough time to give people their medicines safely. One of the staff we spoke with told us, "We're not rushed. I feel I have enough time to complete my medicine round". We observed the medicine being given to people and they were given their medicines in an appropriate way and were given sufficient time to take their medicines. This meant people received their medicines safely.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who 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. A person who has Lasting Power Of Attorney (LPOA) has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions.

Mental Capacity Assessments are completed to help a service determine whether a person is able to retain and weigh up information in order to make a decision. We saw evidence that assessments had been completed however there was one example of an assessment not being fully completed. It was recorded in some people's care records that their relative's had given consent for certain things, such as bed rails and care plans on the person's behalf. There was no evidence available that the relatives held any legal decision making power under the MCA. This meant that the service was not acting in accordance with the MCA to ensure that people's legal and human rights were respected and upheld.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. We found that the registered manager had identified a number of people who they believed were being deprived of their liberty. They had made appropriate DoLS applications to the supervisory body. Staff had been trained about DoLs and were able to tell us about DoLs and what that meant for the people they support.

People we spoke with told us they were offered choice and staff checked for their consent prior to supporting them. One person we spoke with told us, "They [the staff] offer me choice, they always offer for me to go to the dining room or if I prefer to stay in my own room". Another person we spoke with said, "I get up when I want and go to bed when I want" and another person said, "They help me choose my clothes". We also observed people being offered choice. For example one person had a visitor and a member of staff offered the person the choice of where they would like to go and spend time with their visitor. People told us that staff checked with them first before supporting them, one person said, "They check for my consent before supporting me". Staff were able to tell us about the principles of the MCA and how they support people to be able to make decisions, such as presenting information in a different way so people can understand it. This meant that these people were supported to make choices about their own care.

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. A relative we spoke with said, "They seem well trained and knowledgeable, they know [relative's name] well". Staff told us they had the training and skills they needed to meet people's needs. Members of staff had confirmed to us they had received training when they first started working in the home and were supported to refresh that training. One member of staff told us they had in depth medicine training when they started administering medicine which included face to face training, online and they were monitored for two weeks

by a more experienced member of staff. Another member of staff also explained that the deputy manager would observe staff delivering care in order to check their competency and discussed this with the staff member if required. The registered manager also explained they had arranged further staff training to help staff to spot the signs of deterioration in the health of people and how to support people who were coming towards the end of their life, although this extra training had not yet been carried out at the time of the inspection. This meant people were supported by staff who had sufficient training and were encouraged to refresh and develop their training where possible.

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "We've just had a supervision, we have them approximately monthly and we cover performance and any training needs. They are pretty good". Another member of staff said, "I had one last week, we have them quite regularly". We also saw evidence of staff meetings being held and subjects such as training, fire safety and dignity were discussed. Staff told us they felt supported by the registered manager. This meant staff were supported in their role and the guidance they received helped them to be more effective in caring for people in the home.

People told us they liked the food and were able to make choices about what they had to eat. One person we spoke with told us, "The food is very nice here". Another person we spoke with said, "I like breakfast. I get two choices at lunch and tea and if I asked they would get me something else". A relative we spoke with said, "They like the food, they get to choose what they have to eat". We also observed people being offered choices and encouraged to drink and assisted to make a decision when necessary. For example, one person was finding it difficult to choose a type of drink to have so the member of staff brought over a selection so they could view them to make a more informed decision.
We also saw staff encouraging people to eat throughout the lunch period and offered support where necessary. Some people also needed support to maintain their nutritional intake to remain healthy and ensure they did not lose weight. For example, one person had lost weight since they had come to live in the home. The home had made a referral to the dietician who prescribed supplements to ensure the person did not continue to lose weight. The service also had plans in place to encourage the person to eat enough to avoid losing more weight. We also saw evidence of people being regularly weighed so the staff could see if someone had lost weight or not and saw on some occasions that people had put weight on since living in the home This meant people were supported to eat a meal of their choice, maintain their nutritional needs and were assisted when they needed it.

People had access to health care professionals. Records confirmed people had access to a GP, dentist, physiotherapist, and an optician and could attend appointments when required. One person we spoke with said, "I see the GP and I see the dentist". Another person we spoke with told us, "If I say I am not well, they get the GP for me. Nothing is too much trouble for them". A relative we spoke with told us, "The GP comes and sees [relative's name], and the District Nurse". We spoke with a visiting District Nurse who told us, "They [the staff] bend over backwards to help me". We also saw the involvement of health professionals recorded in people's files. One person complained of dental pain and it was dealt with the same day by staff by communicating with the family to discuss options. One member of staff we spoke with told us they seek advice from a local palliative care establishment to support the needs of the people living there, if they needed advice. This meant people had access to a range of health care professionals in order to help them stay well.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us they were happy with the care they received. One person said, "I think it is smashing here, the staff are brilliant and so kind". Another person told us, "If I ask for the littlest thing they do it for you. The little things are important and they make sure everything is ok". Another person said, "The staff are very caring, it is their attitude, they are cheerful and helpful, I can't fault them". A relative we spoke with said, "Nothing is too much trouble for the staff". Another relative we spoke with told us, "The staff have a lot of empathy". We saw staff ensure people were comfortable and assisted people to be more comfortable if they needed to. A relative we spoke to said, "They make sure my relative is comfortable". People told us that they were encouraged to be as independent as possible. One person we spoke with said, "Anything I can do, they let me do it". Another person told us, "Staff are patient and hardworking, they try to help you do things for yourself when you can"

People's dignity was respected by staff. One person we spoke with said, "They call me by my name. They're kind and it means a lot". A relative we spoke with said, "My relative gets treated with respect". We saw a person being encouraged to eat and they appeared confused about how to eat their lunch. The member of staff took time to explain what to do so the person was able to then feed themselves and retain their independence. We also saw staff asking people questions and they would wait for a response and not rush people. Staff would explain to people when they were supporting them with what was happening. We saw two different people being supported to move with the use of equipment and the members of staff were talking to the people and explaining each stage of the process and offered reassurance. We observed staff assisting a person to sit down and they were offering encouragement to the person. We also observed a member of staff gently waking a person so they could be given their medicine and the staff member asked the person about how they were feeling. When we spoke to members of staff they were able to give us examples of how they respect a person's dignity, such as ensuring doors are closed during personal care, keeping people covered and asking them their preferences. This meant people were receiving care from staff who treated them kindly and respected people's privacy.

People received care and support from staff who knew them well. One person we spoke with told us, "They've got to know me and I have a laugh and a joke". People's care was not rushed enabling staff to spend quality time with them. One person we spoke with said, "They are very caring, they speak to me properly and spend time with me". A visiting professional we spoke with told us, "They [the staff] are caring. They sit and have a chat with people and encourage people to reminisce". One staff member we spoke to told us they enjoyed spending time with the people and chatting to them. We saw a staff member spend time with people sitting in the lounge and talking to them. That meant people had meaningful interactions with staff and they got to spend quality time together.

Good

Is the service responsive?

Our findings

People or their relatives were involved in developing their care and support plans. Care plans were personalised and detailed daily routines specific to each person. They had details of people's life history and how they liked to be supported. We also observed staff ensuring people had support that matched their preferences. A relative we spoke with said, "The staff seem to know their needs, they lights up with some staff". We observed one person was asked if they would like anything else after lunch. They chose a cup of tea and were asked if they would prefer it in a china mug or a plastic cup and whether they wanted sugar. We saw the member of staff bring it to them in the way that the person had requested. We also saw that some people chose to wear a protective apron when they ate whereas others had chosen not to wear one. This meant people's care matched their preferences.

We saw that relatives were involved in people's care. One relative we spoke with said, "I look at the files and the staff invite me to reviews" and, "They phone me if [relative's name] is not well". Another relative told us, "I was included in the decision about [relative's name] care" and, "They involved me". On the day of our inspection a relative was visiting and a staff member asked their opinion regarding how they felt about a person's health. They went on to discuss this with a nurse and a plan was decided upon in order to make sure the person felt better again. This meant that the views of the relatives who know people very well are being taken into account in people's care.

People had a range of activities they could be involved in. There was an activities coordinator new in post and it was documented within people's files the hobbies and interests that people had been involved in. For example, one person likes to collect dishes after breakfast and had taken part in pet therapy. One relative we spoke with said, "The activity coordinator takes [relative's name] for a walk". We also observed the activities coordinator spending time with people and playing bowling with people in their chairs, some people chose to play and others chose not to play when it was offered. This meant there were activities available for people to partake in should they choose to.

We saw that meetings were held with people and their relatives and surveys could be completed to feedback their opinions. One person we spoke with said, "I do questionnaires sometimes". The new activities coordinator was introduced to people during a meeting. It was also suggested in one meeting that a computer tablet was bought so people could use it. We saw that this tablet had now been bought and people used it to partake in activities such as going on Google maps to visit places virtually that they liked to go.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. One relative we spoke with said, "I'm able to complain to the manager. Once I asked about something and they looked into it straight away and responded". Another relative we spoke with told us, "I feel very able to complain. They [the staff] explain everything, they are prepared to answer questions and I have never felt brushed aside". Another relative said to us, "I haven't raised a concern but I would go to the manager. I think it would be dealt with". People were given the complaints policy when they moved into the home and a copy was also available in the reception area of the building. Staff we spoke with were able to tell us how

they would support someone to make a complaint if required. There was a complaints file however there had been no recent complaints documented within the file. This meant people knew how to complain and they were responded to in a satisfactory way.

Good

Is the service well-led?

Our findings

We saw audits in place which had been effective. For example an audit had been carried out on the care file of one person and it had identified that a particular safety assessment had not been completed. Upon checking the file following the audit, we saw that this had been rectified, so the correct action had been taken. We also saw examples of both weekly overall medicine audits and medicine audits for particular people which were more in depth, both of which were carried out regularly. Of the audits of medicine audits we viewed, the audited documents verified the findings within the quality assurance documentation which showed the audits had been effective. The registered manager also explained they have carried out observations and spots checks on the service. We saw evidence of observations being carried out in the dining room during the day and visits to the home during the night, so all members of staff were being observed at different times.

People and staff told us that they found the manager approachable and could go to them with concerns. One relative we spoke with said, "I know who the manager is and I find them very easy to talk to". Another relative we spoke with told us, "I feel able to go to the manager". One member of staff we spoke with told us, "They [the manager] are approachable and I can raise things. I've raised things before and it got dealt with" and, "They [the manager] have helped my confidence". Another member of staff we spoke with said, "I have confidence in the management team. The manager is approachable and they take action". The registered manager also told us they felt supported by the provider, they explained the provider visited on a monthly basis to check things have been completed and every second visit, the registered manager had a supervision with the provider. The registered manager also explained they were able to attend meetings with other managers as a support network. They said, "The provider is supportive but I am not restricted so I can get on with things". This meant the registered manager was supported in their role and people, relatives and staff felt comfortable going to them to raise issues.

The registered manager had notified CQC about significant events that they are required to notify us of by law. They also explained how they received information from the provider about health and safety and new policies and guidance. For example, the manager explained about the new method of monitoring urinary tract infections they were using following best practice guidance and we saw this documented in risk assessments for people. This meant the registered manager followed new guidance being made available to improve the quality of service for people.

People, relatives and staff were encouraged to feedback about their experiences within the home via surveys, meetings and on a one to one basis with the staff. The registered manager told us, "Lots of relatives speak to us on a one to one basis". The service valued this feedback and acted upon suggestions made, such as providing people, relatives and staff with a computer tablet to use for feedback or for use during activities. The activities coordinator supported people who needed it to use the computer tablet so they could feedback about their care or any suggestions they wanted to make. This computer tablet was also available to members of staff if they wanted to feed anything back and staff we spoke with told us they knew they could feedback in this way. We saw the collated feedback from people and staff surveys about the home and they were very positive. The feedback from people and staff could be either named or

anonymous if they wished to remain so. This meant people were encouraged to feedback and felt able to and the service uses the feedback to improve.