

Four Seasons (JB) Limited Park House

Inspection report

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Prenton
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Tel: 01516521021

Date of inspection visit:
03 September 2018

Date of publication:
14 November 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on the 3 September 2018 and was unannounced.

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

Park House accommodates up to 111 people in one adapted building across five separate units, each of which have separate adapted facilities. At the time of the inspection there were 93 people using the service many of whom were living with dementia and age-related health conditions.

This is the second time the service has been rated Requires Improvement.

At the last inspection in August 2017 we rated the service Requires Improvement overall. This was because the provider was in breach of Regulation 17 of Health and Social Care Act. There was no system to analyse complaints for themes and trends, the administration of medicines needed to improve and there were no systems to make sure that everyone had the opportunity to participate in customer satisfaction surveys. At this inspection we found that improvements had been made and the provider was meeting legal requirements.

The service has two registered managers one of whom was a registered nurse and was the clinical lead. 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.

Despite the improvements made we found the completion of some records, such as medication administration records and staff personnel records needed to improve. We also saw the mealtime experience and the opportunities for to participate in meaningful activities needed to improve to make sure they met the needs of everyone.

People and relatives told us they felt the service was safe. People were protected from the risk of abuse because staff understood how to identify and report it.

The provider had arrangements in place for the safe management of medicines. People were supported to get their medicine safely when they needed them. People were supported to maintain good health and had access to health care services.

Staff considered peoples capacity using the Mental Capacity Act 2005 (MCA). People's capacity to make decisions had been assessed. People were supported to have maximum choice and control of their lives and

staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People and their relatives felt staff were skilled to meet the needs of people and provide effective care. Staff were supported by management to undertake their roles and were given training updates, supervision and development opportunities.

People were encouraged to express their views and results of customer satisfaction surveys were positive. People and relatives felt listened to and any concerns or issues they raised had been addressed.

Staff supported people to participate in activities of their choice and trips to the local shops and tourist attractions had been organised.

People were supported to eat and drink sufficient amounts and they were given time to eat at their own pace. People's nutritional needs were met and people had a good choice of food and drink.

The service had a relaxed and homely feel. Everyone we spoke with commented positively on the caring and respectful attitude of the staff team which we observed throughout the inspection.

People's individual needs were assessed and care plans were developed to identify what care and support they required. Staff worked with other healthcare professionals to obtain specialist advice about people's care and treatment.

People, staff and relatives found the management team approachable and professional. The manager had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory notifications. The ratings from the previous inspection were on display in accordance with requirements.

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 received their medicines when they needed them.

The premises and equipment were clean, hygienic and well maintained.

There were sufficient number of staff to provide support safely.

There were systems in place to protect people from abuse.

Is the service effective?

Good ●

People's needs had been assessed and staff received the training and support they needed to meet people's needs.

Lawful consent was gained before care and treatment was provided.

People received sufficient amounts of food and drink.

The premises was adapted to meet people's needs.

Is the service caring?

Good ●

The service was caring.

People were supported to be independent and received support from kind, caring and attentive staff.

Records were stored securely and people's personal information was protected.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People were not always supported to become engaged in activities and pastimes they found stimulating and enjoyable. Those that were able had the opportunity to take part in group activities and outings.

Peoples end of life care needs and preferences were planned for.

People's care was kept under review.

Is the service well-led?

The service was not always well led.

Records were not always accurately completed.

There were systems in place to monitor and assess the quality of the service and drive improvement.

The registered mangers were aware of their legal responsibilities.

Requires Improvement 

Park House

Detailed findings

Background to this inspection

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

This inspection took place on 3 September 2018 and was unannounced.

The inspection was carried out by two adult social care inspectors, a pharmacist inspector, a specialist dementia nurse and an expert-by-experience in the care of older people. 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 we checked the information that we held about the service. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. The provider had 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 also obtained feedback from the local authority, the fire authority, a member of the 'Six steps' (end of life) team. We used all this information to decide which areas to focus on during our inspection.

We observed the administration of medicines and the lunch time experience on each of the five units. We also made observations of the interactions, care delivery and activities provided throughout the day on each unit. As some people were unable to give us their views we carried out general observations of care and support including interactions between staff and people. In addition to this we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 13 people, 11 visitors and 20 staff including nurses, unit managers, domestic staff, care staff, an activities co-ordinator and the chef. We reviewed 30 people's medication administration records (MAR), 12 people's care plans, staff recruitment, training and supervision records, health and safety records, accident and incidents, complaints and records relating to the quality assurance and day to day

management of the service.

Is the service safe?

Our findings

People told us they felt safe living in Park House and their comments included, "Home from home, the staff are always popping to see if I'm ok", "The call bell goes to alarm after two minutes so there is always a response" and "Staff will listen and respond to my guidance and wishes if I feel unsafe." Relatives also felt their loved ones were safe. Their comments included, "It's nice to go away and not worry" and "We visit every day and know Mum is well looked after here."

Some relatives and staff felt there was not always enough staff on duty. The registered managers explained staffing levels were based on an assessment of people's needs and had been maintained. They also told us the staffing levels on some units had reduced in line with these assessments but that some staff had remained unhappy about this. They told us they had some staff vacancies which they were covering by using regular agency staff. They told us to cover for staff unexpected leave such as sickness they always scheduled more staff on the duty rota than had been assessed as needed. They explained they moved permanent staff around to try to ensure that there was always regular staff working on each unit and that wherever possible they used agency staff that had worked at the service before. They said they could also call on support from the provider's neighbouring service. When we asked staff what the impact of more staff on duty would be, some told us they would have more time for paperwork whilst others felt they would be able to spend more time with people. We found no evidence to indicate staffing levels were not safe.

Some relatives expressed a concern that agency staff may not have a good understanding of their relatives' needs and preferences particularly at night. However, our findings were that agency staff were provided with an induction to the service and information about people's needs. One agency staff member confirmed to us that they had received a comprehensive handover before they started work and that they felt supported by the management and staff. Another nurse new to a unit told us they had been provided with a list of people's needs before starting work. One relative told us "It's the same girls normally apart from when they are on holiday".

People received their medicines safely. We observed that medicines and oxygen, were stored safely, securely and at a consistent temperature. Staff who administered medicines were appropriately trained. Records were kept of the ordering, receipt and disposal of medicines. Spot checks of the amount of medicines in stock balanced with the amount shown on the records. We saw that staff administered medicines sensitively and appropriately. There was a list of 'homely remedies' which could be administered by staff with the agreement of a GP.

Risks to people's health and safety had been assessed and kept under review. Appropriate action had been taken to reduce risks such as the use of bed rails to prevent a person falling from their bed, use of pressure mats to alert staff if a person got out of bed without assistance and the use of pressure relieving equipment to reduce the risk of developing pressure sores. Moving and handling risk assessments all contained needs specific to the individual in terms of how many staff would be needed to assist and the role of the staff member.

The recruitment of staff was safe. We saw staff had completed an application form and attended an interview. Appropriate checks had been undertaken by the Disclosure and Barring Service (DBS) and staff had not started their employment until these checks had been completed. Personal Identification Numbers (PIN) for the qualified nursing staff were checked monthly.

Each person's ability to evacuate the building in case of emergency had been assessed and recorded on a personal emergency evacuation plan (PEEP). These were detailed and considered sensory issues and moving and handling of the person in question and were explicit in the requirements needed for their safe evacuation from the building.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. The premises and equipment were clean and hygienic. Regular checks had been completed to make sure the building and equipment was safe and routinely maintained. The services kitchen had been awarded a five-star food hygiene rating by the Environmental Health and action needed to address shortfalls identified in a recent infection control audit was being taken for example, due to changes in good practice recommendations, new sinks were being sourced. The provider employed maintenance workers who carried out day-to-day repairs and staff said these were attended to promptly. Accident and incidents had been recorded along with any actions taken to reduce the risk of reoccurrence. These were monitored by the registered manager to identify any themes and trends.

People were protected from abuse. Staff could tell us how they would report any safeguarding concerns and had received training in safeguarding. Where concerns had been identified these had been reported to the local safeguarding authority for their consideration in line with local safeguarding protocols. There were clear policies and procedures available for staff to refer to if needed.

Is the service effective?

Our findings

People received the support they needed to eat and drink sufficient amounts and specialist diets were catered for. Most people were encouraged to eat their meal in the dining areas. Some people chose to eat in their own rooms or from a portable table in the lounges. We saw where required, people received the support and equipment they needed to eat. For example, some people had plate guards, some had drinks in spouted beakers and some people had their food cut up for them and some people had coloured plates which made it easier to see the food.

Most people were satisfied with the food they received and their comments included "I can have anything I want if I don't like what is on offer", "Staff are always asking if I would like a drink", "Always plenty of choice, I like mash and mince best" and "I get whatever I need". Three relatives felt the food was acceptable. Staff monitored people's food and drink intake where needed and checked for signs of dehydration or weight loss. People were weighed regularly and if they had lost weight or been identified at risk of malnutrition or dehydration, advice had been sought from an appropriate health care professional. One relative told us their loved one had been losing weight when living at their own home had gained weight since moving in.

People's care and support needs were assessed before they began using the service. The pre-admission assessment was used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan.

People and their relatives told us that their loved one's received the support they needed to access healthcare support. One person's relative told us "The girls are great, can't fault them, they know their jobs". Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's, chiropodists speech and language therapists (SALT) and social workers. Access was also provided to more specialist services, such as opticians and podiatrists as required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals.

Staff received the support they needed to undertake their role and received regular supervision and an annual appraisal of their performance. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff had completed training the provider considered to be essential to meet people's assessed needs. Training including health and safety, fire safety, dementia care, personal care and person-centred care, food hygiene and infection control and was provided throughout the year and at different times of day so that all staff could attend. New staff completed an induction to the service and shadowed other staff before working unsupervised. Staff new to care completed the care certificate. The care certificate is a nationally recognised qualification designed to provide staff new to care with the skills and knowledge they need to provide safe and effective care.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We observed most staff talked to people and sought their consent before initiating care interventions. For example, asking people if they were ready to stand, asking if they were ready for their medicines. We saw where it had been deemed in a person's best interest to administer medicines covertly or via a feeding tube we saw that the required paperwork had been completed and that a Pharmacist had been consulted. The management and staff understood the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty and saw documentation that supported this.

The premises had been purpose built and had lift to all floors and wide corridors painted in dementia friendly colours to enable people to easily move about their home. Each of the bedrooms had an en-suite and had been appropriately and personally furnished. There were signs on toilet doors illustrated with symbols to aid people's orientation.

Is the service caring?

Our findings

People were supported with kindness and compassion. During our inspection we witnessed many examples of staff demonstrating kindness and compassion towards the people. Staff knew the needs of each person, they listened to them and spoke to them respectfully and in a way they could understand.

People told us caring relationships had developed with the staff who usually supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. People's comments included, "Nothing is too much trouble", "I am always consulted on my needs", "I talk to staff a lot especially in the hut" (smoking area), "Just ask and they do it", "The staff are lovely people and there's always someone to chat to", "The staff are very helpful, I get everything I need" People's relative's comments included "Involved in care plan from the start", "Staff always helpful" and "The staff have been amazing, it's made such a difference, I would give them 10 out of 10".

Everyone we spoke with thought they were well cared for and treated with respect and dignity. From talking with people, their relatives and staff, it was clear that they knew people well and had a good understanding of how best to support them. People looked comfortable and they were supported to maintain their personal and physical appearance in their own chosen style.

We saw that staff were respectful when talking with people, referring to them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. When we observed lunch, we saw people being helped to eat, with kindness by staff. We observed one member of staff knelt at the person's level while supporting them and showed patience ensuring the person did not feel hurried. People told us they could choose for themselves how they spent their time and what they wanted to do throughout the day. They said they could choose what time they got up, when they went to bed and how and where to spend their day.

The registered managers recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Staff supported people and encouraged them, where they were able, to be as independent as possible. For example, to eat and drink independently and to walk. Care staff told us they prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair and to dress. Staff encouraged people to maintain relationships with their friends and families and to make new friends with people living in the service. People were introduced to each other and staff supported people to spend time together, in this way friendships were formed within the service. Visitors were able to come to the service at any time, and could stay as long as they wished. Visitors told us they were welcomed and could make themselves drinks on the units.

One relative told us, "We visit on most days; at all different times of day and we are always made welcome". Staff engaged with visitors in a positive way and on relative commented "Happy my relative is well looked after, the home is like a community".

People's individual beliefs were respected. Staff understood people wanted to maintain links with religious organisations that supported them in maintaining their spiritual beliefs. Discussions with people on individual beliefs were recorded as part of the assessment process.

Records were stored securely in locked offices and on password protected computers. Information governance training via e learning and new updates in relation to General Data Protection Regulation (GDPR) had been communicated to all staff.

Is the service responsive?

Our findings

At the last inspection we identified the range of activities available to people to keep them stimulated and engaged needed to improve. The registered managers told us since that time the activities programme had been further developed and the range of activities on offer had increased. A staff member confirmed this and told us that they supported people to participate in games, singing, exercises and going out into the local area to cafes. Trips had also been organised to the cinema, Chester zoo, Liverpool museum and a trip on the Mersey ferry. One to one time was also spent with people in their rooms and social events such as the 'knit and natter' groups had been set up. During the summer some people had helped in the garden and participated in planting and painting plant pots.

There were activity boards on each unit to inform people what activities were available but as at the last inspection, these were not up to date and people did not know what activities were on offer that day. Three activity organisers were employed to provide activities to people across all five units. We were told that one of these was on holiday on the day of the inspection and their role was not being covered. We did see an activities organiser playing the guitar and singing to people on one unit and were told they would be visiting each unit. One relative told us their loved one spent most of their time in their room and staff always made sure the television was tuned to the sort of programmes they enjoyed but some people and their relatives didn't feel enough was offered to people who spent time in their rooms. This is an area of practice that needs further improvement.

From 1st August 2016 all organisations that provide publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of people with a disability, impairment or sensory loss. Some information was available to people in a format accessible to them such as pictorial menus but these were not being used on each unit.

There was some signage in place to help people orientate themselves around the service such as signs on toilet doors and signs to indicate fire escapes. However, there were no visual aids in communal areas to help to support orientation of people with dementia to move around the home and increase their awareness of their environment or orientate them to the day of the week or time of year. The door of one person who was living with dementia had been personalised to reflect their favourite football team but most people's doors had not been personalised. The registered manager told us this was an area of practice they had identified and they were working to improve this.

The quality of people's mealtime experience varied and was not always responsive to people's needs. For example, although most staff were attentive and supportive, pop music was playing in one unit which made sociable conversation difficult because the music was too loud. Several units had no napkins or condiments available. There was no choice offered to people who required food that was 'fork mashable'. On one unit, staff followed good practice by showing people living with dementia plates of food to choose from but this did not happen on every unit.

We discussed the above issues with the registered managers who gave assurances that they would take immediate action to address our concerns. Following our visit, they sent us documentation confirming what action was being taken to improve the experience for people. The dining experience is an area of practice that needs to improve and be sustained to make sure it meets the needs of everyone who uses the service.

Care plans contained information on people's communication needs and how to communicate with them effectively. Staff confirmed they were aware of people's communication needs and told us how they adapted their approach to sharing information with some people with communication difficulties. For example, by making eye contact and speaking clearly and making sure people wore their hearing aids and spectacles. One relative told us that their relative was not able to speak and needs clear instructions and eye contact from staff when communicating with them. The relative confirmed that staff had discussed these needs with them in detail and documented their relatives needs in a care plan which they said they had been "Fully involved in from the beginning".

Care plans emphasised the importance of making sure people's hearing aids were working and that they were supported to wear them. They also highlighted the need for people to wear their spectacles. Information could be provided in large text for people with a visual impairment. The providers web site had software that enabled the information to be 'read' aloud to people. There was also a facility to increase the size of the text and alter the contrast to assist people with a visual impairment. The software also enabled the information to be translated into other languages.

Care plans and associated risk assessments had been regularly reviewed and updated to reflect any changes in care needs. However, some lacked detail about whether the person and where appropriate, their relatives had been involved in this process. Some care plans also lacked details about the person's preferences for food and activities. These are areas of practice that need to improve.

Throughout the inspection, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding to requests for assistance. People and their relatives confirmed people had call bells they could use to alert staff when they needed help and that these were usually responded to promptly.

Complaints were managed well and responded to in a timely manner. We saw the complaints procedure on display contained details of who people could contact if they had any concerns. We looked at the complaints log and saw that complaints were recorded including the date they were received, the date they were resolved and whether the complaint was substantiated or not. There was a complaints board within the reception area to raise awareness in how to make a complaint. There had been several complaints over a couple of years about the heat in some areas of the service due to the lack of air conditioning units. These concerns had been taken seriously and new units had been installed. People and staff told us this was an improvement.

People's wishes on their end of life care had been documented and plans put in place to ensure that their preferences were met. We saw people's wishes on whether Cardiopulmonary Resuscitation (CPR) should be commenced in the event of a heart attack had been sought and documented appropriately on a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. Some staff had received end of life training and we saw cards from people's relatives thanking the management and staff for the care that their loved one's had received at the end of their life. The registered managers told us they and five staff had signed up to the local 'six steps scheme' which is a nationally recognised end of life care programme and were due to start in December 2018. They were also working closely with the local GP surgery in implementing end of life care plans and emergency healthcare plans. They told us they had formed good links with the palliative care

team in the local authority and felt well supported by them.

Is the service well-led?

Our findings

At our last inspection in August 2017 we found significant improvements had been made to the management and the oversight of the service. However, we also identified a in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems in place to monitor people's satisfaction by way of satisfaction surveys and through speaking to people were not always effective and there was no evidence that complaints had been analysed to identify themes and trends. At this inspection we found that improvements had been made and the breach had been met.

The registered managers and provider were carrying out regular audits to ensure that the service was providing quality care safely. Satisfaction surveys were conducted and had been improved to make sure everyone who used the service had the opportunity to give their views. There were systems and processes in place to ensure safety, cleanliness, safe medicines management and care delivery. When shortfalls had been identified action had been taken to rectify them. We also saw one of the registered managers had oversight of the complaints that had been received and was checking for any themes and trends.

Improvements were needed to make sure all records were fully and accurately completed. For example, some personnel files contained no photographic identification, there were gaps in some staff's employment history and some files did not contain evidence that their induction was complete. PEEPS were not all signed and dated and some people's MAR had no photograph of the person and some contained gaps. The MAR for four people stated their pulse was to be recorded but there were no records to confirm this. The position of some people's pain relief patches had not always been recorded and two people's MAR did not detail if they had any allergies. The registered managers sent us documentation after our visit confirming an action plan was being followed to make sure these issues were addressed. These are areas of practice we identified need to improve and be sustained.

The registered managers told us they were working to change the culture at the service and working with staff to encourage them to be more open to working in different units across the service. They said although the sickness levels amongst staff were still high, they had reduced from over 10 percent to 6.9 percent. They told us they were also addressing performance issues with some staff and that some staff had left their employment as a result.

Most people, visitors and staff told us that they were happy with the way service was managed and that the management team remained approachable and professional. We also saw people and their relatives came to speak with the unit managers throughout the day and most relatives and staff spoke highly of the support they had received from the registered managers. One relative told us they felt the management was "excellent" and that one of the registered managers had "explained absolutely everything" including showing them the last CQC report before their loved one had decided to move in. Most staff spoke highly of the registered managers and enjoyed working at the service. One member of staff commented "I love working on the unit with people with dementia". They also told us they felt supported by their unit manager and the registered managers saying they were "lovely".

People looked happy and relaxed throughout our time in the service. The registered managers demonstrated they had a good knowledge of people by describing people's personal backgrounds, preferences and personality traits. There were processes in place to seek feedback on the service people received to identify areas in need of improvement.

The registered managers told us they continually looked to improve and had liaised regularly with other professionals involved in people's care to share information and learning around local issues and best practice in care delivery for example, end of life care. This learning was cascaded down to staff. They had also taken immediate action to rectify shortfalls identified as part of a recent infection control audit completed by the local authority.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered managers had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.