Care Quality Commission

Mr & Mrs C Bennett
Park House
Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection was unannounced and took place on 13 May 2015.

Park House is a care home without nursing, which provides care for up to 21 people. People who live at the home are older people who may be living with a dementia or have mental health needs.

There is 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.

The home was not always safe. People were not always protected from risks presented by other people who lived at the home, or from risks associated with the building. This was because risk assessments lacked necessary detail, did not contain sufficient guidance for staff, sufficient control measures or had not been updated to reflect changes.

Systems to assess and review the quality of care provided had not always been successful in identifying shortfalls in practice or inappropriate care. Some areas of the building were looking tired and some rooms had an odour problem.

People were not always protected by the home's understanding of legislation in place to protect their

Summary of findings

rights. A recent safeguarding concern had indicated that staff had carried out actions that had not been in line with the Mental Capacity Act 2005. However, staff on the inspection demonstrated an understanding of the Mental Capacity Act 2005 and the principles of consent.

People did not all have clear care plans detailing their needs or how they were to be met. One person did not have a completed care plan despite being at the home for nearly four weeks and other supporting information about their needs could not be located. Other people's plans did not all include sufficient detail to determine how their care was to be provided or their needs met consistently.

People were able to take part in organised activities, but these would benefit from development. We have made a recommendation in respect of activities to meet the needs of people living with dementia.

People were protected from the risks associated with medicines, but we have made a recommendation about the medicine storage facilities.

Staff were creative in encouraging people to eat well. The home's chef had suggested new themed menus that involved serving meals from different countries throughout the world, with a different country each day. Menu plans offered a choice of three main dishes, three side dishes and two dessert options for the main meal for people to select from. People were offered choices just prior to the meals being served, and the meals served were hot and appetising. People really enjoyed the meals they ate and extra helpings were available. The registered manager told us that they had monitored the meals taken and found that not only had waste been reduced but people were enjoying the meals more and putting on weight.

Risks of abuse to people were minimised because staff had received training in recognising and reporting abuse, and staff had a clear understanding of what constituted abuse. Where concerns had been identified the home had taken appropriate action to support people and safeguard their well-being.

People were protected by the home's staff recruitment procedures, and there were sufficient staff on duty to meet people's needs both by day and night. People benefitted from good visual clues and information available to support them to retain their independence and navigate themselves around the building.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Applications had been made for deprivation of liberty safeguards authorisations where people were considered to be deprived of their liberty.

People received care and support from staff who had the skills and knowledge to meet their needs, and had access to community healthcare services.

Staff knew people well and were positive about their care. Staff spoke about people with concern for their well-being. Care was given to preserve people's dignity, and staff were respectful of people's choices for example with regard to dress.

People benefitted from an effective system to manage complaints or concerns about the home. The registered manger and staff learned from events or incidents and were creative about putting learning into practice.

We found a number of breaches of regulations and you can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 health and welfare had not been fully assessed or kept under review, and therefore appropriate action had not always been taken to protect people. Risk assessments were not updated following significant incidents, which left people at risk.

People were safeguarded from abuse, and there were enough staff to support people and meet their needs. A full staff recruitment process was in place.

People were being protected by the home's systems for the management of medicines.

Is the service effective?

Requires improvement

The home was not always effective.

People did not always benefit from an environment that promoted their well-being. People's capacity to consent to locked doors had not been assessed properly in accordance with the Mental Capacity Act 2005.

People received a well-balanced, creative and nutritious diet that met their needs and preferences.

People were able to access supportive information to enable them to find their way around the building independently. Staff communicated well with people and had the skills needed to support them.

Is the service caring?

Good

The home was caring.

People were supported by staff who knew them well and were positive about their care. Staff spoke about people with concern for their well-being.

People's dignity was respected.

Information about people was kept confidential and staff involved people in maintaining their independence.

Is the service responsive?

Requires improvement

The home was not always responsive.

People did not all have clear care plans detailing their needs or how they were to be met.

People were able to take part in organised activities.

People benefitted from an effective system to manage complaints or concerns about the home.

Summary of findings

Is the service well-led?

Requires improvement

The home was not always well led.

People were clear about the management structure of the home and staff told us they felt well supported.

People were not always protected as systems to assess and review the quality of care provided had not always been successful in identifying shortfalls in practice or inappropriate care.

Records were not all well maintained. In particular risk assessments and some care plans were not up to date or comprehensive enough, and records had not been amended to take account of new legislation.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 May 2015 and was unannounced. It was carried out by an adult social care inspector 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, 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 looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

On the inspection we spoke with or spent time with 15 of the 19 people who lived at the home, three visitors and five members of staff. Many of the people who lived at the home were not able to share their experiences with us verbally as they were living with significant dementia. We spent several short periods of time carrying out a SOFI observation. SOFI is a specific way of observing care to help us understand the experience of people who could not communicate verbally with us. We contacted the local commissioning and quality team prior to the inspection and also spoke with a social worker from the older person's mental health team to gather their views about the service.

We looked at the care plans, records and daily notes for five people with a range of needs, as well as other records in relation to the operation of the home such as risk assessments and policies and procedures. We toured the accommodation, and looked at service areas such as the laundry and kitchen.

Requires improvement

Is the service safe?

Our findings

The home was not always safe. We identified concerns about risks from the environment as well as people who lived at the home.

People were not always protected from risks presented by other people who lived at the home. For example, one person presented behaviours that were challenging, and had been involved in a significant incident in the days prior to the inspection. Their risk assessment had not been updated as a result of the incident. The guidance for staff on how to manage the individual's behaviours was not comprehensive enough to ensure the person received consistent care and support or that the impact of their challenging behaviours was reduced. We asked the registered manager to take immediate action to address this. One person told us "No, I don't feel safe at the moment and I'm really worried."

People were not protected by risk assessments undertaken of the environment. The risk assessments were brief and did not contain sufficient detail on the control measures taken to reduce risks or cover all areas of risk at the home. For example we saw that control measures lacked detail, and included general statements such as "robust cleaning schedules" or "clinical waste to be used appropriately". Some risk assessments had not been updated to reflect changes at the home, for example the Fire Precautions (workplace) risk assessment had not been reviewed since March 2014, despite changes having been made to some locked doors. The registered manager told us that they walked round the home each day to identify any new risks in the environment, and this process was documented.

This was a breach of regulation 12 (2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans contained risk assessments aimed at reducing risks to individuals in relation to malnutrition, falls and swallowing difficulties. Known allergies were clearly recorded, and assessments were reviewed regularly to ensure they were still accurate.

Risks of abuse to people were minimised because staff had received training in recognising and reporting abuse. Staff had a clear understanding of what constituted abuse. Where concerns had been identified the home had taken appropriate action to support people and safeguard their well-being. Staff showed knowledge of policies and procedures about raising concerns and told us these were readily accessible to them. One staff member told us about how they would know through people's body language if they were unhappy about something. Staff understood how and to whom concerns should be reported, and information was available throughout the home on external agencies to contact to 'whistle blow'.

People were protected by the home's recruitment procedure for new staff. This included carrying out checks to make sure new staff were safe to work with vulnerable adults. The files for three staff members were seen, and found to include the required documentation and checks. Where concerns were identified about staff members appropriate disciplinary action was taken by the provider. There had been very few changes to the staffing team since the last inspection. One staff member told us "We've got some nice girls now – a good team".

People were supported by sufficient numbers of staff to meet their needs. Staff knew people well and could both understand and anticipate their needs and wishes. We had arrived at the home around 7am so that we could meet with the night staff. They told us they had been busy overnight but people's needs had been met. Six people were up and dressed when we arrived at the home, and one staff member was available to give them drinks while other people were being supported by the second waking night staff member to get up. During the day we saw people being supported by the staff team in a timely way. The atmosphere was calm and people who were spending time in communal areas were supported by a member of staff.

People were protected from the risks associated with medicines. Medicines were administered by staff who had received appropriate training to carry out the role. Records were kept of each administration and where the quantity of medicine to be given varied with the person's symptoms these were clearly recorded. Medicine was given to people with an explanation of what it was, and time was given for them to take it at their own pace.

The home used a blister pack system with printed medicine administration records (MAR). Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. One person refused to take their medicine

Requires improvement

Is the service safe?

while we were observing the medicine round. The staff member attempted to persuade the person to take their medicine, but when the person refused again this was accepted and the records completed to reflect the refusal. The staff member told us that if the person regularly refused their medicines they would be referred to their GP. No controlled drugs were at the home at the time of the inspection.

Some people were prescribed medicines on an 'as required' basis, and there was guidance available for staff to ensure that this was used in accordance with the prescribing instructions. Some people received their medicines covertly, and this had been discussed with the person's GP and advocate or relative before decisions had been made and recorded. Best interest decisions had been recorded in line with the requirements of the Mental Capacity Act 2005 (MCA).

The medicine cupboard was not easily cleanable, as it contained wooden shelving that had been covered with sticky tape that was now in a poor condition. **We recommend that the service seeks advice and guidance from a reputable source about the suitability of the medicines cupboard in use.**

Requires improvement

Is the service effective?

Our findings

The home was not always effective.

Although staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA), a recent safeguarding concern indicated that staff had carried out actions that had not been in line with the MCA to protect people's rights. This related to people's capacity to consent to locked doors, and was under a safeguarding process at the time of the inspection.

People did not live in an environment that always improved the quality of their life or promoted their well-being. Park House is an older period building adapted to be a care home. Some areas of the fabric of the building were looking tired and some rooms had an odour problem associated with incontinence or poor hygiene. In some areas this was significant, and was discussed with the registered manager, who told us that carpets were replaced regularly and furnishings cleaned. One person told us they did not have hot water to their room, and action was taken immediately to remedy this. Some adaptations had been made to the building to improve people's quality of life and well-being. For example, a fenced area of garden had been enclosed to the rear of the building. However, people would still need staff assistance to access this area.

People received care and support from staff who had the skills and knowledge to meet their needs. Three staff files were seen, one of which related to a recently employed non-care worker. This file did not yet contain a fully completed induction programme, however the files relating to care staff did. Staff training needs were assessed and regular training and updates were provided to ensure staff had the skills they needed. Staff told us that they had received the training and support they needed to help care for people. Recent training had included infection control, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, moving and positioning and equality and diversity. Staff received appraisals and supervision which identified training needs.

Staff communicated well with people. There were good visual clues and information available to support people retain their independence and navigate themselves around the building. For example there were signs letting people know where they could go for a cup of tea and another sign letting people know that the staff wearing coloured uniforms could give them help and support. Colour coded tablecloths were used to help people identify mealtimes.

People were asked for their consent or agreement before staff assisted them with any tasks. Staff told us about how they supported people and understood that they were consenting to the care being delivered. One staff member described the care they had delivered to one person that day. They told us and demonstrated how the person indicated clearly through their body language what they wanted.

People received nutrition and hydration that met their needs. Assessments were carried out of people's nutritional status and people were weighed regularly to monitor weight gain or loss. People were supported with eating and drinking where they needed this, or received additional monitoring due to assessed risks of choking. People could also choose where they wanted to eat their meals. One person chose to remain in the dining room during the day and other people stayed in their rooms. One person told us "I lock my door because I like to be on my own and I don't want other residents coming in…I'm very independent and I don't want to mix".

People were offered choices in relation to their meals, and the home was creative in encouraging people to eat well. The home's chef had suggested new themed menus that involved serving meals from different countries throughout the world, with a different country each day. Menu plans offered a choice of three main dishes, three side dishes and two dessert options for the main meal for people to select from. People were offered choices just prior to the meals being served, and the meals served were hot and appetising. People really enjoyed the meals they ate and extra helpings were available. The registered manager told us that they had monitored the meals taken and found that not only had waste been reduced but people were enjoying the meals more and putting on weight.

Drinks were offered throughout the day, and people sought out staff for additional drinks or snacks which were offered. Where fluid balance charts were needed as people were at risk of poor hydration these were audited daily to ensure that they were properly completed and totalled for each 24 hour period. This helped ensure that any concerns over people's hydration were quickly identified and action plans put in place.

Requires improvement

Is the service effective?

People had access to community healthcare services that met their needs. Evidence in people's files showed that they had access to dentists, chiropody and optical care. Community nurses visited to monitor people's health and were attending to support one person with dressings. Staff we spoke with were clear about the risks associated with diabetes management and understood signs that the person may be becoming unwell.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Applications had been made for deprivation of liberty safeguards authorisations where people were considered to be deprived of their liberty.

Good

Is the service caring?

Our findings

The home was caring.

People told us they were supported by kind and caring staff. They said "The staff will do anything I ask…they help me with everything" and "I like it here. You couldn't have nicer people"

Staff were observed supporting people throughout the day. Staff responded quickly and patiently to peoples' requests. For example we saw one person came down independently for their breakfast early in the morning. Staff immediately prepared the person's breakfast of choice for them and laughed and joked with them about their preferences and lifestyle. People's idiosyncrasies and personality traits were accepted and staff celebrated achievements with people, no matter how small they may have seemed. For example one person ate their meal independently, despite this taking a long period of time. The person was supported to do this rather than being hurried along by staff. Staff praised the person for completing this independently.

Staff patiently responded to people's repeated questions, and used effective distraction techniques to help reassure and divert people from their concerns or risky behaviours. Staff spoke about people with concern for their well-being.

People's privacy was respected and all personal care was provided in private. Staff spoke quietly and discreetly with people when asking them about support they needed. They were aware of issues of confidentiality and did not speak about people in front of other people. When they discussed people's care needs with us they did so in a respectful way.

Visitors told us they were able to come at any time. Most people who lived at the home had a single room where they were able to see personal or professional visitors in private. A quiet lounge was also available if people wanted to meet with visitors in private.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. Staff knocked on people's doors before entering their rooms. Some people who had capacity to make the decision had chosen to lock their doors.

Staff had thought creatively about providing information to people about their surroundings, using colour, photographs and print to provide visual clues and information to help keep people independent. There was a large noticeboard in the hallway with photographs of staff on duty and information such as meals available. People's rooms were identified with pictures of significance to them, such as pictures of their pets to help them identify their personal space. Explanations were given to people at an appropriate pace to allow them to understand the information and respond in their own time.

Requires improvement

Is the service responsive?

Our findings

The home was not always responsive.

Care plans were personalised to each individual but did not all contain sufficient information to assist staff to provide care in a manner that fully met people's needs or wishes.

We looked at the care files and plans for four people. The file for one person who had been most recently admitted to the home (four weeks previously) did not have a care plan in place. We were told that the home would use the initial assessment documentation for the first four weeks to enable them to support the person while learning about their needs. However the initial assessment documentation for this person could not be located. This meant that there was no detailed plan in place of how the person's needs were to be met.

Another care plan we looked at did not give sufficient information about how the person's behaviours were to be supported. Care plans were bulky documents which meant it was not easy to identify current practice or needs.

This is a breach of Regulation 9(3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other care plans and records we saw contained assessments of people's physical health, mental health needs and personal care required, along with the actions needed to support them. A visitor we spoke with told us that they were involved with their relative's care and felt able to make suggestions to the home but had not wished to be involved in the development of the person's care plan as they felt that "was the home's job".

People received care that was responsive to their needs. Staff told us about the need to keep plans for the day flexible to assess and manage the behaviours of people who could be unpredictable. The night staff told us that one person had been up for much of the night despite their efforts to assist them back to bed. One staff member told us "You need to go with the flow here with people, as you never really know what they are thinking or feeling each day. It is our job to keep up with what they are feeling. "

People who could express their preferences for their care had this respected. For example we spoke with a member of staff about the care they had delivered that morning to a person. They could tell us in detail about the person and the life they had lived, as well as how they liked their care to be delivered. Another staff member told us about how one person liked to dress, including the importance to the person of wearing colourful accessories. A relative we spoke with told us "I am very happy with (their) care. Sometimes little things go wrong, but I trust the staff to know how to look after her and sort things out. They have never proved me wrong yet."

The complaints procedure was given to people and their relatives at the point of admission and was on display in the home. Complaints were acted upon promptly and a response sent to the person with an apology or an indication of actions to be taken to prevent a re-occurrence. People we spoke with told us they would feel free to raise any concerns with the management or would tell their families if they were unhappy about anything. One person said "There's nothing wrong with it so I don't have anything to complain about".

People were able to take part in organised activities, according to their interests. The registered manager gathered information from families about people's previous life history where they were able to do so. This was to help staff support people with memory loss with knowledge of the lifestyle choices the person had made prior to losing their memory. Staff told us for example that one person had an interest in gardening and they were hoping to engage them in garden based activities once they had settled in. There was a programme of activities on the wall in the lounge, including notes on people's known hobbies and interests. People spoke about the singing sessions which they enjoyed. One person told us "I go out once a week with staff to do my own shopping". Other people told us "People come in and we go out for walks with people" and "I don't know what we do, but we have a good time".

On the day of our visit we saw the hairdresser was in the home. They were attending to people in one person's bedroom. We saw this person was engaged with the hairdressing, handing rollers to the hairdresser and chatting with people having their hair styled. They told us they did not mind this happening in their room.

We recommend the provider seeks further advice and guidance from a reputable source on developing the provision of positive activities to support people living with dementia.

Requires improvement

Is the service well-led?

Our findings

The home was not always well led. Prior to the inspection the provider had completed a provider information return or PIR. Some of the information presented in this document was not found to be correct, for example that all people who lived at the home had a 'person centred care plan'.

People were not always protected by the home's quality assurance or quality management systems. Systems to assess and review the quality of care provided were in place but had not always been successful in identifying shortfalls in practice or inappropriate care identified during this inspection.

Records were not all well maintained, in particular care plans and risk assessments. The registered manager was starting to update records to reflect the new Regulations that came into force in April 2015. Some records were accessed using a tablet computer to which we were told staff would have access, and others were kept as paper copies, for example care plans. The home does not have a dedicated office, so records were kept in filing cabinets in a corridor area, in the dining room or on the tablet computer. This meant that staff had to be vigilant in ensuring that people's confidentiality was respected when taking records to write them up. No records were left unattended during the inspection.

The provider and registered manager had put quality assurance systems in place to monitor care and plan on-going improvements. Audits and checks were in place, for example infection control audits, mattress audits and medicines, and these had been effectively completed. The provider and registered manager had responded where previous shortfalls in the service had been identified by either internal audit or external inspection, and actions had been taken to improve practice. For example the home had been inspected by the Environmental Health Department of the local authority and awarded a low rating due to the failure to complete records in relation to systems for safe food management. We saw that this had been attended to immediately and a re-inspection requested.

People were encouraged to have a say in the way the home was run. Questionnaires were circulated to stakeholders to gather their views on the quality of the service and what could be improved.

People benefitted from a clear management and staffing structure at the home. People who were able to speak with us told us they knew who was in charge and who to go to in case of any concerns. Senior staff were always available and management back up was available over the telephone outside of hours. Staff told us they felt supported in their role.

Systems were in place to ensure staff understood the tasks they were to complete each day. For example carer cards detailed the daily duties of staff for each shift. Handover sheets ensured that any changes were passed on for staff attention, and staff worked well as a team. The registered manager told us that staff meetings were held but that one had not been undertaken for some time.

Staff were creative about using learning to improve practice and support people's well-being. Suggestions from staff following training they had undertaken were trialled and implemented where it could be demonstrated that improvements in care followed. For example staff had attended a course on end of life care and learned about the benefits of moisturising creams for people in improving hydration levels overall. People were offered this along with increased fluids and the number of urinary tract infections at the home had decreased as a result.

The home has notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who used services and others were not protected against the risks associated with their care and treatment through regularly updated and comprehensive risk assessments and by doing all that is reasonable practicable to mitigate those risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care he registered person had not designed a care and treatment plan for each person living at the home, with a view to ensuring the person's needs were met.