Parkfields Nursing Home Limited

Parkfields Nursing Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 4 and 9 December 2014 and identified four breaches of legal requirements. This was because people's medicines were not managed safely, allegations of abuse had not been reported, people's care was not always planned and delivered in a way that protected them and effective systems were not in place to ensure people were protected from unsafe care and treatment.

After the comprehensive inspection, the provider wrote to us and told us how they were going to meet legal requirements in relation to the breaches. We undertook a focused inspection on the 16 and 18 June 2015 to check that they had followed their plan and to check whether they now met legal requirements. We found that the provider had not fully met their legal requirements in relation to some of the breaches, although they had addressed others. We also found one additional breach of regulation 11 in respect of people's consent to care.

Summary of findings

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Parkfields Nursing Home' on our website at www.cqc.org.uk.

Parkfields Nursing Home provides care and treatment for up to 49 older people that may have a physical disability. The home provides nursing care, which means qualified nursing staff are always available. There were 34 people living at the service when we undertook this focussed inspection.

The registered manager had left the home since our last inspection. A new manager had commenced managing the home three weeks before this focussed inspection and told us they were going to apply to be the registered manager. 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.

At this focused inspection we reviewed the breaches we had identified and told the provider about. We found that the provider had made some improvements in the way they monitored the quality of care and treatment people received. We found that there were more robust systems in place to monitor risks to people's health and well-being. We saw staff were respecting people's dignity and privacy. Systems were being introduced to ensure that staff were better deployed. Most people told us staff responded to their requests for assistance better. We found there was still scope for the provider to improve systems. For example, ensuring the safe management of medicines, consistent involvement of people in their care and record keeping. This meant the provider had not fully addressed this breach in respect of how the quality of the service was monitored.

We found the provider had improved the frequency of their auditing for medicines and we saw that there were some improvements that ensured people received their medicines as prescribed. However, we found gaps in these audits and saw the systems for the management of people's medicines were not always safe. This meant the provided had not fully addressed this breach.

In response to the breach regarding allegations of abuse or incidents of actual harm to people not being reported to the appropriate agencies we found improvements. The manager and staff were aware of how to raise safeguarding referrals and we have received prompt notifications of such incidents and allegations when they had been made since our previous inspection. We found the provider had addressed this breach.

We found that the care and treatment of people's fragile or broken skin had improved and some people's broken skin had healed. There were still some areas where improvements could be made to ensure the progress of people's fragile skin was better monitored. Based on the improved outcomes for people with fragile skin, we considered the provider had addressed this breach.

Some people had not been involved in the planning of their care and as a result their choices as to how, for example the medicines were given to them, had led to a potential breach of their human rights.

You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'requires Improvement '. The rating for the domain safe has remained at inadequate and as a result the service has been placed into 'special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which the providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measure will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if

Summary of findings

they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The provider had taken some action to improve safety but there were still areas which meant the service was not always safe.

Allegations of abuse or incidents where people have been harmed had been reported to other agencies appropriately. Staff had a better understanding of how to ensure allegations of abuse were reported.

The provider had made some improvements in the management of people's medicines but there were still instances where we found improvement was still needed to ensure people received their medicines as prescribed, and that they were safe.

We will review our rating for safe at the next comprehensive inspection.

Is the service effective?

Requires improvement

We found that action had been taken to improve effective care and treatment but there were still areas which meant the service was not always effective.

The care of people's broken skin was more effective. There was still some scope for further improvement in ensuring equipment was used correctly and record keeping was better maintained.

People's choices in respect of how they took their medicines were not always sought.

We will review our rating for safe at the next comprehensive inspection.

Is the service caring?

Requires improvement

We found that some action had been taken to ensure the service was more caring.

We found that staff were now respecting people's privacy and dignity.

We will review our rating for safe at the next comprehensive inspection.

Is the service responsive?

Requires improvement

We found that some action had been taken to make the service more responsive.

People shared mixed experiences about their involvement in planning their care. The manager expressed a commitment to ensure people's involvement was improved in a way that was robust and meaningful.

We will review our rating for safe at the next comprehensive inspection.

Summary of findings

Is the service well-led?

We found that some action had been taken to improve how the service was led.

There had been some improvement in how the provider monitored the quality of the care and treatment people received, although there were still areas where these needed to be more robust to ensure people's safety.

We will review our rating for safe at the next comprehensive inspection.

Requires improvement

Parkfields Nursing Home

Detailed findings

Background to this inspection

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

We undertook an unannounced focused inspection of Parkfields Nursing Home on 16 and 18 June 2015. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 4 and 9 December 2014 had been made.

The inspection team consisted of one inspector, one pharmacist inspector, a specialist advisor (who was a nurse) 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 we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements. We also spoke with the local authority about their views of the service.

During this inspection we spoke with 15 people who lived at the home, two visitors, the manager, four nurses, five care staff, an administrator, a cleaner and the maintenance person. We spoke with three visiting health care professionals. We also spent time looking to see how people were cared for and supported by staff.

We looked at nine people's care records (including eight people's medication administration records) and other records related to the management of the service for example audits of medicines, action plans and staff meeting records.

Inadequate

Is the service safe?

Our findings

At the previous comprehensive inspection we found that there were occasions where the provider had not taken steps to protect people against the risks associated with the unsafe use and management of medicines. There were instances when the provider was unable to show that people had received their medicines as prescribed.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection we found that the provider had not followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12.

We found the medicine refrigerator temperatures were not being measured correctly to ensure the medicines stored would be effective. Readings taken on the day of the inspection showed the refrigerator temperature was below the acceptable minimum temperature. We found that the refrigerator was storing temperature sensitive medicines and as a consequence of these temperatures the provider was advised to obtain new supplies of the medicine and discard the current stock. We spoke with the manager and nurses about the effectiveness of the fridge in storing medicines safety and they told us a new fridge was on order.

People we spoke with told us they received their oral medicines when needed and they had no concerns about how these were given to them. We found that most people received their oral medicines as prescribed by their doctor. However, we had concerns that an issue identified at the last inspection had not been addressed by the provider. A person who had been prescribed an antibiotic which needed to be administered on an empty stomach was still receiving it with or just after their meals, which meant the antibiotic would not work properly. We were made aware this was the choice of the person concerned. There was however no assessment of risk and discussion with person to confirm that they knew about the risk of taking these antibiotics in this way. We also found that a person had one of their medicines discontinued. This medicine was contained in the monitored dosage system and a nurse told us that they were separating this tablet from the rest of this person's tablets before the administration process took place. The provider was unable to demonstrate that all of the nurses were following this procedure and therefore there was the potential that this person may have received the discontinued medicine.

We found that the administration of prescribed creams was not managed well. We found the prescribing information on creams (and ointments) was not specific and the term 'as directed' was being used. We were unable to find in the provider's records what this term meant for each individual prescribed cream. We found that the nursing staff were signing the medicine administration record twice a day for each prescribed cream even though they were not administering them. We found that trained care staff were administering the prescribed creams and had their own recording template to record when they had applied the prescribed creams. We looked at these records and found that the application of these prescribed creams was not being carried out consistently. We found prescribed creams were dated when opened. Based on the date and the frequency at which these creams should have been applied it was evident that some people's prescribed creams were not applied as required.

We looked at the records for two people who were having patches for pain relief applied to their bodies. We found that the recording of where these patches were being applied had improved in both cases. We found that one of these records was able to demonstrate that the patches were being applied in accordance with the manufacturer's guidance. The other, however showed that the patches were not being applied safely in accordance with the manufacturer's instructions and could result in unnecessary side effects.

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

At the previous comprehensive inspection of the home we found that there were occasions where people had raised allegations of abuse and the provider had not taken appropriate steps to, or ensured that such allegations of abuse were reported to the relevant agencies. The previous manager had demonstrated a poor understanding of local safeguarding procedures.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated

Inadequate

Is the service safe?

Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection we found that the provider had followed the action plan they had written to meet the shortfalls. We had received prompt notification of all allegations of abuse the provider became aware of since the previous inspection, and these had also referred to the local safeguarding authority who leads on investigating such matters. We discussed local safeguarding procedures with the new manager and they demonstrated that they had a good understanding of their responsibilities in respect of reporting allegations of abuse or incidents where people might have suffered harm. They also understood the importance of these procedures. Nurses we spoke with showed a better awareness of safeguarding procedures than they had at the previous inspection and were able to tell us how they would raise a safeguarding alert in the absence of the manager. Other staff we spoke with also understood how to recognise and report abuse.

Most people we spoke with said they were able to talk to someone if they felt unsafe. One person said, "If I feel worried I can tell the carer or manager" and another person told us, "I've got my family if I want to talk to them". A third person said, "[The manager] pops in every now and again and asks if everything is alright but I've no complaints". People told us they had no concerns about the safety of their valuables and property.

At the previous comprehensive inspection some people told us that they had to wait for their care because there was a delay in staff answering their call bells. Staff also told us they had no time to complete some important tasks. For example, they said, and we saw, on one day they were late serving breakfast for some people. This meant there was only a small gap until these people were served their lunch and therefore they were not hungry when offered their lunch. At this focussed inspection people told us, "I don't use (the buzzer) very often. It's surprising how quick they come" and, "We've all got to press the buzzer. Reasonable amount of time for the staff they've got on." A third person said, "I've a buzzer. Sometimes they come quick, sometimes they don't". We saw that staff responded to people's needs and requests for assistance within a reasonable timeframe during this inspection and steps had been taken to ensure people did not have a late breakfast unless this was their personal choice.

The manager told us they were looking to develop the provider's staffing tool to help identify the number of staff needed based on factors such as the layout of the premises. We saw that the number of people living at the service had decreased and staffing numbers had remained the same since December 2014. We also saw that there was better deployment of staff in that they were allocated to areas within the home. The manager told us that this was to be further developed to a team approach. Staff we spoke with confirmed that deployment of staff was clearer and more organised. They confirmed changes the manager had made which allowed them to spend more time with people at peak times, while completing less time critical tasks at quieter periods. We found some people on bed rest in their bedrooms on the first floor did not have access to their call bells and staff were not based on this floor. The manager told us that they would ensure that these people had access to a working call bell so people could alert staff in between their hourly checks if they required assistance. The majority of people we spoke with told, or showed us that they did have access to their staff call bells.

Requires improvement

Is the service effective?

Our findings

At this focussed inspection we found that a person had decided to refuse some of their medicines. Following the advice gained from the person's general practitioner, the provider had started disguising these medicines in the person's food. We found that this person had the capacity to make decisions for themselves and therefore the provider had denied this person their human rights by taking this course of action. We were told that the covert administration had taken place for about a week and the person concerned was now taking their medicines in the conventional way.

We also found that some people, who had been self-administering prescribed inhalers at the last inspection, were no longer doing so. We were told that the last manager had instructed nurses to take over the management of the medicines these people were self-administering, this after we had asked why their ability to manage these medicines safely was not risk assessed at our fully comprehensive inspection. We asked these people if they had made a choice not to self-administer this inhaled medication, and if they had been involved in a decision for the staff to take responsibility for their medicines administration. One person indicated that they were satisfied with the decision not to self-administer the inhaled medicine, while the other person said that they had not been involved in the decision. When asked if they would still wish to self-administer their inhaled medicine they said that they would. They told us that the staff had ensured that they received their inhaled medicine when needed. This showed that this person's consent had not been considered in the process of stopping them self-administering their inhaled medicine.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous comprehensive inspection of the home we found that there were occasions where people's care was not always planned and delivered in a way that ensured they were protected against the risks presented by poor health, specifically the risks to people with fragile skin.

This was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this focused inspection we found that the provider had taken action to address the shortfalls in relation to the requirements of Regulation 9.

People told us that staff would respond appropriately if they were feeling unwell. One person told us, "I should have to stay in bed; they'd bring my meals up and get a doctor". Another person said, "They would go and tell the doctor and nurse". A third person told us when they had felt unwell the nurse had, "Called the emergency doctor, then the ambulance. I was in hospital in the matter of an hour".

Commissioners had shared concerns with us about some people's care as they had developed avoidable pressure ulcers prior to this focussed inspection. We found that these people's pressure ulcers had healed. However one person still had a care plan that reflected care of the person's pressure ulcer rather than a prevention plan for their fragile skin. We also found that some people's air mattresses were not at the correct settings for their weight even though staff did tell us these were checked daily. This presented a risk that they may be ineffective in protecting people's skin. We discussed this with the manager who promptly brought it to the attention of the staff. We also discussed with the manager the lack of regular records that described people's skin condition and photographs to evidence progress of their skin.

We spoke with a visiting health care professional who said there was still scope for improvement in staff knowledge. We found some nurses had limited insight in safe techniques to promote wound management. In discussion with the health professional we were informed they were arranging training for nurses in wound management in order to develop their knowledge, skills and confidence, relevant to the needs of people living at the service. We found there was regular involvement of appropriate health care professionals in respect of the care of people's fragile skin. Despite some shortcomings in staff knowledge and recording we found where people had developed broken skin areas, the action staff had taken had promoted the healing of people's skin. This showed that despite a need to improve record keeping the provider had ensured the healing of people's fragile skin was promoted.

Requires improvement

Is the service caring?

Our findings

At the previous comprehensive inspection we heard from some people that they or an appropriate representative had not always been involved in the planning of their care. At this focussed inspection people's experiences were mixed. Some people felt they were able to have involvement where other people told us they did not always feel involved and well informed. The manager told us that they were looking to develop systems for consultation with people through care plan reviews, surveys and meetings that would help them monitor people's perceptions around the quality of the service they received. The manager had only managed the home for a short period of time and had not had time to fully implement these measures, and stated that such measures needed to be introduced in a way that fostered people's meaningful involvement.

At the previous comprehensive inspection we found people's dignity was not always respected by staff, and at the point care and support was offered they were not offered choices or the opportunity to consent. At this focussed inspection we found that improvements had been made. People told us, "They do respect my privacy. If you want help they will give it to you, they [the staff] are good" and, "They have got good manners, They are very nice". A third person told us staff were, "Respectful at all times" and said, "I've got my own privacy when I need it". We observed staff providing people with care and support and they consistently offered people choices. When staff provided people with personal care they used screens to promote people's privacy. People told us they were happy with the choices provided to them. We saw people were offered choice at the point staff assisted them, for example, at lunchtime people were asked about the food they wanted and offered choice. We also saw staff talked with people when assisting them, telling the person what they were doing, offering choices and encouraging them with their meal.

Requires improvement

Is the service responsive?

Our findings

At the previous comprehensive inspection we found people's views were not always captured through the provider's systems for involving them in their care and treatment. At this focussed inspection people gave us mixed views about their involvement. One person said, "I have filled in questionnaires. There's a complaints procedure book. There's supposed to be meetings but I don't think I've ever been to one. You get one or two involved and that's it". Some people were unsure how they could raise their views, although some were confident they could tell staff who would talk to them about their care. The manager recognised that people's involvement in their care, and the running of the home could be better and told us how they planned to promote this, for example reviewing every person's care plan over a period of time and setting up meetings with people and their relatives. They told us that they wanted to introduce this process in a way that promoted meaningful involvement of people.

Requires improvement

Is the service well-led?

Our findings

At the previous comprehensive inspection we found that there were occasions where the provider did not have effective systems in place that would protect people against the risks of inappropriate or unsafe care and treatment.

This was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result we served a warning notice on the provider and told them they must ensure there were effective systems in place that would protect people against the risks of inappropriate or unsafe care and treatment by 21 April 2015.

At the previous comprehensive inspection we found that there was no robust systems in place to check people received their medicines as prescribed. Audits were not completed or effective in identifying discrepancies in stock that were indicative of people not receiving their medication as prescribed. Advice from an earlier Wolverhampton Clinical Commissioning Group (CCG) pharmacy audit had not been followed. At this focused inspection we found the provider had increased the frequency of their auditing for the oral medicines and as a consequence we saw improvements in the recording and administration of those medicines. These audits had not included the monitoring of other areas in the management of medicines and we identified a number of issues where the management of people's medicines needed to improve.

At the previous comprehensive inspection we found there was no overall system for the provider to monitor people's safety in respect of the risks to them presented by their fragile skin. We found that people had not received care in accordance with the risk of skin breakdown that nurses had identified in their records. In addition care plans related to people's treatment of their fragile skin were not always in place. At this focussed inspection we found that a nurse had been allocated to oversee the quality of people's care. The nurses we spoke with were aware of which people had pressure ulcers or were at high risk of developing these, and we saw the manager had systems to ensure they were able to identify people at higher risk due to their health.

There was still scope to improve some recording in respect of monitoring people at risk of broken skin that would help strengthen the provider's systems for monitoring risks to people's health.

At the previous comprehensive inspection we found the provider's governance systems did not identify people at high risk of weight loss and we were not assured through observation of staff practices that these risks were responded to appropriately to promote people's well-being. At this focussed inspection we discussed with nurses how they identified people with weight loss and what actions they took to escalate concerns about a person's well-being. The nurses were able to explain how they monitored people's weights and we saw there were reviews by appropriate health care professionals, with evidence that their recommendations were followed up, for example, through the provision of dietary supplements. People we spoke with told us they were encouraged to eat with a choice of foods and we saw staff provided positive encouragement to people with their meals at lunch time.

At this focused inspection we found that the provider had not met all the issues raised within the warning notice, this so as to meet the shortfalls we identified in relation to the requirements of Regulation 10. We also identified additional areas that showed there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager, who was also the nominated individual for the provider had ceased their involvement in the management of the service as of the 31 March 2015. A new manager had taken over the running of the service three weeks prior to this focussed inspection. They showed us a revised and robust action plan where they had identified a number of priorities for the service so as to ensure improvements were initiated. This was based on their initial findings and those of visiting commissioners. They shared their 'vision' for development of the service, which included development of the staff team so that they were aware of their personal responsibilities. We spoke with staff and they were aware of the new manager's expectations and were positive about development of the home. We saw this had been discussed with them in staff meetings held. We saw that staff had been delegated key areas of responsibility and during the course of the focussed inspection staff were able to explain these to us.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **People were not always involved in making decisions about their care and this had on occasion compromised their human rights.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines were not consistently managed in a way that was proper and ensured people's safety.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems were not robust enough to ensure that risks relating to the health, safety and welfare of service users were consistently addressed.**