Ideal Care Homes Limited

Hurst Park Court

Inspection report

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Date of inspection visit: To Be Confirmed
Date of publication: 27/08/2015

Ratings

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

Overall summary

We carried out our unannounced inspection of Hurst Park Court on the 08 and 13 of July 2015. Hurst Park Court is a care home which provides accommodation for up to 41 adults. The service is located in the Huyton area of Knowsley and is close to local public transport routes. Accommodation is provided over two floors and the first floor can be accessed via a stair case or passenger lift.

At our last inspection in July 2014 we found that people who used the service were not protected against the risks of receiving care that is inappropriate or unsafe and that the systems in place did not identify, assess and manage risks relating to the health, welfare and safety of people.

The registered provider sent us an action plan advising us how they had actioned this.

There was not a registered manager in post, however a new manager had been appointed and in post for one month, 'A registered manager is a person who has

Summary of findings

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 new manager had previously been the deputy manager at the home. She informed us that she was in the process of registering with CQC as the registered manager.

At this visit we found that people were not protected against the risks associated with the administration, use and management of medicines. People did not always receive their oral and topical medicines at the times they needed them or in a safe way. You can see what action we told the provider to take at the back of the full version of the report.'

We found that staff had received training about safeguarding and knew how to respond to any

allegation of abuse. We found there were enough staff on duty to keep people safe. Throughout the inspection we observed members of staff interacting in a positive way with the people who used the service and with their visiting relatives.

The registered provider had carried out necessary health and safety checks to ensure the premises were safe for the people who lived and worked there.

The food menus were varied and two choices were offered at every meal. We observed some people being supported with their meals by members of staff. Some people had specific dietary needs, which were appropriately catered for.

We were told by people who lived in the home, their relatives and members of staff that the manager was approachable and supportive.

A complaints policy and procedure were available. People who lived in the home and their relatives told us they would feel confident to raise any concerns if they needed to.

Staff we spoke with had a good understanding of the needs of people they supported and were positive about their role and the support they received from the service. Staff received on-going training to ensure they had up to date knowledge and skills to provide the right support for the people they were supporting. They also received regular supervision and appraisals.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLs) and to report on what we find. DoLs are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. At the time of the inspection of Hurst Park Court there was one person who was subject to a DoLs authorisation. The manager and the staff had received training and had a good understanding of the Mental Capacity Act 2005 (MCA) and best interest decision making, when people were unable to make decisions themselves. We found that people who lived in the home had been asked for their consent before receiving support. We saw consent forms which had been signed and dated by the person who used the service or their representative, with the person's permission and consent. However more information on best interest decisions should be recorded in accordance with the MCA 2005.

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

We saw that a variety of activities and entertainment had been available to people, in order to provide stimulation and motivation.

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.

People who lived in the home told us they felt safe living there. Relatives also confirmed that they felt the service was safe.

Medicines were not always stored correctly and people did not always receive their oral and topical medicines at the times they needed them or in a safe way.

Staff were appropriately recruited, with the necessary checks being carried out to ensure that they were of suitable character and had the appropriate skills.

Is the service effective?

Good

The service was effective.

People who lived in the home received effective care, as staff had a good understanding and were knowledgeable of people's care and support needs.

Staff were supported to carry out their roles and they had received the training they needed to meet people's needs.

People told us the food was good, they had different choices and different dietary needs had been catered for.

Is the service caring?

Good

The service was caring.

People's rights to privacy and dignity were respected and staff cared and supported people in a calm, relaxed and unhurried manner.

People told us they were pleased and happy with the care and support they received. This was also confirmed by relatives.

Staff assisted people with activities, promoting independence, self-esteem and providing stimulation.

Is the service responsive?

Good

The service was responsive.

Staff had good knowledge of people's care needs and support was provided in accordance with their care plans.

People told us and we observed that staff listened to them and responded to their requests for support.

A satisfactory process was in place for managing complaints and people told us they had no complaints.

Summary of findings

Is the service well-led?

The service was not always well-led.

Positive comments were received about the new manager, about being approachable and helpful.

There were quality monitoring systems in place including, audits and checks and survey questionnaires, however the medication audits had failed to pick up the issues identified at this inspection.

Requires Improvement

Hurst Park Court

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 08 and 13 July 2015 and was unannounced. The two day inspection was carried out by two adult social care (ASC) inspectors on the first day and one ASC and a pharmacist inspector on the second day.

During our inspection we spoke with four people who lived at the home, we looked at the records of five people, spoke with five relatives, met with seven members of staff and conducted general observations throughout both days, including lunch time. The care records we looked at were individualised, detailed and informative for the care staff.

We found there was a relaxed friendly atmosphere in the home and people appeared comfortable and at ease with the staff.

The records relating to the management of the service were also reviewed, including quality audits and health and safety inspection checks. We also looked at three staff files, the food menus, the staff training matrix, recruitment records and the file which contained the Deprivation of Liberty Safeguards (DoLs).

Before the inspection we spoke with the local authority's safeguarding team and the contracts monitoring team to check if they had identified any concerns or issues on their monitoring visits to the home. No concerns or issues had been identified.

Requires Improvement

Is the service safe?

Our findings

People told us, "Oh it's good here. I feel safe, but I don't like the dark" and "The staff are brilliant, can't fault them in all honesty. Not a bad one here". Some of the comments from relatives included, "I do feel she is safe. I have never seen or heard anything untoward", "I leave here with a happy heart", "I can always find a member of staff and there is always someone supervising in the main lounge "and "There seem to be plenty of staff around". However one person said, "(name) has a lot of falls. They never send a member of staff to hospital with (name). It is so traumatic for her. A&E don't understand her condition. I've raised it with staff and been told it is not their policy to escort people to hospital". However, Ideal Care Homes policy states an escort is required for all transfers to hospital. Two other people raised concerns about the high temperature in the home and particularly in the bedrooms. This meant there was a possible risk of dehydration. We saw air conditioning units in use in communal areas. In discussion with the manager it was mentioned that they had been having some remedial work done to ensure that the temperature in all areas was comfortable and acceptable.

We looked at people's medication records, medicines and other records of care, both planned and received for eight people who were living in the home.

Medicines in current use were generally stored safely in locked cupboards and trolleys. However we saw some topical medicines (for external use) had been left in a public bathroom where they could be accessed by visitors or people living in the home. We also found two medicines that had been left in the medicines trolley rather than being kept in the fridge as recommended by the manufacturers. Medicines must be kept safely, securely and at the correct temperature at all times in order to protect people living in the home against the risks associated with the unsafe storage of medication.

We looked at medication records for a person who had recently had their medicines changed following a short stay in hospital. Instructions had been received to increase the dose of one medicine and to add a new medicine. These instructions had not been followed, meaning that the person had received only half the dose of the first medicine and none of the second for ten days. We also saw that the person had gone without nutritional supplements as stock had run out before a new supply had been obtained.

Medication records showed that most people received their medicines correctly; however we did find examples where people had not been given their medicines as prescribed. For example, one person was prescribed eye drops to be used four times a day, but these had only been used once a day for the last seven days. We saw that one person's records indicated they had been away from the home at the time their medicines were due and it was unclear if their medicines had been given or omitted at those times. Records for the use of creams and other external preparations were incomplete and unclear meaning that in some cases we were unable to tell who had applied these products and whether or not they had been used as prescribed.

Many people were prescribed creams and medicines, e.g. painkillers and laxatives that could be given at different doses i.e. one or two tablets or that only needed to be taken or used when required. We found that care plans were generally in place for the use of these medicines, but in some cases there was not enough information available to enable care workers to give the medicines safely. This was of particular concern where staff had a choice of products, e.g. laxatives, but did not know which medicine should be offered first or when it was necessary to introduce or switch to a different medicine. We saw no evidence of pain assessments being carried out to determine whether or not people living with dementia were in pain. The lack of information about some people's individual needs and preferences meant that they were at risk of not being given their medicines safely.

We looked at records for two people with arrangements in place to be given their medicines covertly i.e. hidden in food or drinks without their knowledge or consent. These arrangements had not been made in accordance with the Mental Capacity Act 2005 or current NICE guidance and had not been reviewed for over six months. There was no information with the care plans or MARs to tell care workers which medicines were to be given covertly or exactly how and in what circumstances they should be given. It was impossible to see from records which medicines had been given covertly and which had been given with the person's knowledge and consent.

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

Requires Improvement

Is the service safe?

We observed a clean, odour free and comfortable environment. The communal areas contained good furnishings. Relatives said, “It’s always clean”, “I was becoming concerned about how grubby the place was becoming. I’m happy to see they are starting to paint”.

We observed people to be calm, relaxed and content, with members of staff interacting with people in a positive and compassionate manner. There were eight carers on duty on each day of our inspection.

Wallpaper decorating was taking place in two of the lounges on our first inspection day. The pasting tables in use were not screened off from people and posed a potential hazard. Additionally a medication round was in progress and we were concerned the staff member could be distracted if people did approach the area which was being decorated.

We observed people being appropriately and safely supported between rooms and from chairs to the dining room tables.

We saw a wide range of risk assessments in place in peoples care files including, falls risk, moving and handling and managing people’s personal safety. The risk assessments had been reviewed on a monthly basis.

Sensor mats were in use in a number of bedrooms, these sensors were used to detect if a person got out of bed at night and this would raise the alarm for staff. Regular two hourly checks were recorded during the night. We saw records to show that people had been taken to Accident & Emergency following a fall.

Instructions for hand hygiene in the bathrooms and toilets and supplies of soap and paper towels were available. We tested the water temperature in several bathrooms and found it was appropriate for use.

Each bedroom had a lock. Staff had master keys and people kept them locked if they so wished. All bedrooms had a door to the garden area and people had to request for the garden door to be unlocked by staff. We observed two people accessing the garden area. Store rooms, electric mains room, mechanical plant room and clinic rooms were securely locked. All bedroom windows were fitted with restrictors which limited how far they might open and helped prevent people from falling through them.

We saw a number of wheelchairs in bedrooms. One of these had badly worn tyres. We were told it belonged to the person and was not the property of the provider. However it was clearly in use in the home. The manager said they would check who was responsible for the maintenance of this wheelchair and ensure it was made suitable for use.

We saw that the registered provider had the necessary recruitment and selection processes in place. We found that appropriate checks had been carried out, including evidence that pre-employment checks had been made such as written references and satisfactory Disclosure and Barring Service clearance (DBS) checks.

Good

Is the service effective?

Our findings

People who lived in the home and relatives told us that the staff were really good and always helped them. Some of the comments were, “If you want a sandwich they bring it. We have good cooking in this home”, “The dinners are lovely” and relatives said, “Sometimes she gets food she doesn’t like but overall she does like it” and “She enjoys the meals. The quality of the food is very good”.

We found that people’s care and support needs had been assessed before they moved into the home. People had relevant care plans in place, which had been completed with input from health and social care professionals, helping to show that people received relevant and appropriate care, in accordance with their individual needs and wishes. Care files contained written consent for care and treatment, consent for the use of photographs. The consent forms were signed and dated by the person or by their representative.

Records demonstrated that people had received visits from health care professionals, such as doctors, district nurses chiropodists and opticians. The registered provider had been proactive in accessing appropriate health care and treatment for people, when it was needed.

Hurst Park Court had two large lounge / diners and two smaller quiet lounges. People could use their own bedrooms for privacy and for seeing their visitors. Meals were served wherever the person preferred, with the option of two dining areas or their own room. We observed that staff assisted people with their mealsand this was done in a respectful and dignified manner. Relatives told us they believed people enjoyed the food. The food we saw served was attractively presented.. There were pictorial menus displayed on boards in the dining room. The dining tables were set with linen. An electric serving trolley was brought to the dining areas and immediately plugged in to ensure that food was hot when served. We saw people eating breakfast which was a choice of a hot breakfast or a continental style. People had been consulted in advance about their preferences for lunch. Staff also brought the plates of food to people and asked which item they preferred. Lunch was a choice of two small meals (quiche and beans or sandwiches and soup) and a dessert.

One person who did not like her choice and was quickly attended to and an alternative was provided. The menus were on a four week cycle and were varied. We spoke with the cook, who was aware of individual’s specific dietary needs. We saw menu ordering sheets that monitored which dishes were most popular. There was a white board in the kitchen which displayed the names of people who had allergies or any dietary needs. For example one person was insulin dependent, soft food diets were identified for others and the display also contained the names of people with allergies i.e. Allergic to strawberries, allergic to eggs and another person was allergic to spicy food.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLs) and the Mental Capacity Act (MCA) 2005.The MCA 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people’s best interests. DoLs is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw 29 applications for standard DoLs authorisations. One application had been authorised. An MCA screening tool was seen on each file. This provided a generic assessment of a person’s ability to make decisions.

We noted that a sensor had been fitted in one person’s room following consultation with their key worker and care coordinator but not their next of kin. Files referred to decisions made in a person’s ‘Best Interest’ but there were no notes of meetings or evidence of who was involved in that decision making process.

A training matrix was available and we saw that staff training was up to date and relevant to meet people’s needs. Training certificates and evidence of staff induction were in staff files. Training provided included, safeguarding, first aid, administration of medicines, dementia awareness, moving and handling, MCA & DoLS and diabetes.

We saw records of monthly staff supervision sessions and bi-annual performance appraisals. This showed that the registered provider was interested and committed to staff development.

Good

Is the service caring?

Our findings

Comments from people who lived in the home and their visitors were, “The girls will always help you”, “I like it very much”, “They are always discussing her care with me. I am asked to go through the care plan and raise any issues”, “They make you welcome, they go out of their way for you.” and “The staff bond with the people. They all do a very good job”.

We observed family members visiting during both days without any restrictions, with visitors being made welcome and offered drinks by staff. We saw and heard staff interacting with people in a calm and polite way and saw that these supported people’s wellbeing.

Staff encouraged and motivated people to participate in the activities that took place. Staff were friendly, patient and discreet when they provided support to people and were very patient with people’s choices of food over lunch and tried hard to encourage people to eat.

People’s bedrooms were bright , airy, well decorated and were personalised with photographs , pictures, plants and ornaments. Each bedroom was equipped with a TV, telephone point and a small fridge.

One person had a fall in the lounge and we observed members of staff providing appropriate first aid, reassurance and compassion. Two members of staff remained on the floor with the person until the paramedics arrived. One carer said, “We always call for an ambulance if someone has a fall, we never assume the person will be alright”.

People’s care documents indicated that they and their families had been involved with their admission assessments. Care plans contained good information about people’s background history, their likes and dislikes.

The information and guidance in care plans was descriptive, relevant and appropriate information for staff, helping them to meet people’s care and support needs. Care plans were reviewed and updated on a monthly basis.

One member of staff said, “I am involved in updating and reviewing care plans. We like to get families involved” and “ some people are unable to communicate and one person doesn’t like to have male carers. We obtained that information from their relative”. Personalised care plans helped to demonstrate that individualised support and care was promoted and provided.

Two visitors spoken with said, they had been kept well informed about their relatives. One person indicated that communication could be improved via emails with updates. Other comments included, “(name) is settled now, the staff are smashing”, “They ask us if she can be taken out. We are in the decision making process” and “(name) has confidence in the staff, they look after (name)”.

We observed staff knocking on people’s bedroom doors before entering. We heard people being asked if they needed anything and there was consistently good humoured interaction between staff and residents.

The staff comments regarding how to promote dignity and respect were, “We have to ensure dignity is provided everyday, confidentiality is the key thing”, “Always tell the person what you are doing and make sure privacy is provided, like closing curtains and covering the person with a towel” and “We have had dignity training and we make sure people are respected at all times”.

The manager informed us that if someone needed an independent advocate, they had the contact details for an external advocacy agency. We saw a poster on the home’s notice board advertising an advocacy service for people who might need support to voice their wishes and needs, if they had no one to represent them.

Good

Is the service responsive?

Our findings

Some of the comments from people were, “I do what I want” and “ the outing was lovely”. Visiting relatives said, “They seem to have a good programme of activities. They take them out to the village and the lay preacher comes to see her”, “They got the doctor when I asked” and “when I asked if something could be done. They come and do it right away, they are very good”.

People’s care plans were individualised and focussed on the person’s specific needs, their likes and dislikes. The care files contained personal profiles with emergency details, GP, social worker, and any medical diagnosis. Pre-admission assessments included the person’s social background history and their aspirations as described by the person or their representative. The initial care plan was initiated from the assessment. Care plans were stored securely in dining areas and were accessible to the relevant members of staff’.

Care plans contained various aspects of people’s identified needs which included: communication and respect, dementia, skin integrity, hygiene and personal appearance, food and nutrition, management of medicines and personal safety. Care plans had been signed either by the person or their representative. Monthly care plan reviews were carried out. Relatives told us they were invited to be involved in these reviews. This person centred information gave guidance that helped staff provide an individualised service.

We looked at charts which recorded nutritional intake and fluids taken, dietary needs and preferences and weights. We saw accident/incident forms which recorded and described falls people had experienced. Each person had a daily communication record in their care file, which recorded the care given, people’s mood, any visitors whether relatives or heath care professionals, any bruising or heath issues and involvement in activities. The daily records were completed twice daily. Other records were maintained to show when health professionals visited the person including, GP, Chiropodist, District Nurse, Mental Health team and Optician.

There was a keyworker system in place, which meant that a named carer was assigned to each person. Part of the keyworker’s responsibility was to ensure that the person had a supply of toiletries, new clothes as needed, escort people to on outings and liaise with family members.

People could choose to sit in the quiet lounges or where there was no TV. The seating in the main lounges was arranged in small groups to encourage socialisation.

There was a programme of activities available to people living in the home. A timetable of activities was on display in reception on a large TV monitor, Some of the activities available were, arts and crafts, takeaway nights, bingo, pet therapy and sing-alongs. The local branch of the Alzeimers Society held a monthly event at the home, which a number of people attended.

We overheard a staff member speaking with a person about their previous employment in a natural and interested way. The person responded in a positive manner, reminiscing about their working life. One person was asked if they would like to play Bingo. The person replied, “Thought you may be doing something more intellectual”. The staff member replied, “would you like me to read to you or do a crossword instead”.

We asked people who lived in the home and their relatives if they had any complaints. Comments they made included, "No complaints at all, it’s fine here” and “No I have never needed to complain, but I would if I needed to”. We checked the complaints policy and procedure and found it was up to date, with satisfactory timescales for responding to a complaint. No complaints had been received by the registered provider.

In discussion with management it was decided that a suggestion box would be placed in the reception area of the home, with people being able to raise a concern anonymously, if they wished to.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke positively about the manager. The following comments were made, “Concerns or issues are always dealt with by the manager. I’m delighted she is now the manager. She is very, very helpful”, “The manager knows every resident”, “I wouldn’t hesitate to go to the manager” and “We can’t fault it here, I’ve never seen a home run as well as this one”. Relatives said they were confident in the abilities of the home manager who had worked at the home for many years as a senior carer and as a deputy manager for some time. They felt they could approach her with concerns and she would take action.

There was no registered manager in post. The manager informed us that she was in the process of applying to CQC to be the registered manager of Hurst Park Court.

We received positive feedback about the manager from members of staff, including, “Ever since we were told about the new manager, staff morale increased”, “We are one team now” and “It’s improved so much with the new manager”. Overall, people said the manager was really approachable and the home was well run.

The manager told us they had bi-monthly meetings with people and their relatives. One relative said, “I go to the relatives meetings which are held every couple of months” Minutes of the meetings were provided to us. They included discussions about menus, activities and dignity and respect. The actions taken were displayed on the notice board for all to see.

Two visiting health professionals said, “I have been here about six times, always found the manager and staff friendly, helpful and knowledgeable” and “They provided files when I asked for them. They are really helpful”. We observed the manager discussing a person’s wellbeing with a health professional. The discussion was professional, informative and focused specifically on the person who lived in the home.

The registered provider had appropriate quality monitoring systems in place including, survey questionnaires provided to people who lived in the home and their relatives. This was to obtain people’s views and opinions of the service delivery. The surveys were sent out monthly. Most of the comments were positive including, “The staff are wonderful” and “The place is always tidy and clean”, however others wrote, “Could do with more staff”, Need to take more care with the laundry” and “Clothes not been tagged as promised”. Some compliments had been sent to the service including, “We as a family have appreciated your dedicated approach to help everyone at Hurst Park, but we would like to sincerely thank you for looking after (name) in such a family friendly way” and “Comforting for the family to know, she was in a safe and happy environment”.

There were other systems in place to monitor the service provision including, audits {checks} for care plans, medication, health and safety and accidents and incidents. Although medication audits had taken place, the checks had failed to recognise the failings with the storage, the recording and the administration of some people’s medicines.

The registered provider’s representative carried out monthly ‘compliance visit record checks’ and a report was drawn up with the findings, with what action was needed to rectify any issues that had been identified. We looked at the most recent one, which was June 2015. As an example, it was identified that a fire drill had not been carried out for two months and the action was, ‘Fire drills are to be completed on a monthly basis’ and ‘all body maps are to be evaluated on a monthly basis, even if there are no marks, staff should then document “skin intact”. However, the compliance visit check had also failed to discover the issues with the management of medication. This potentially placed people at risk of harm.

The manager understood her responsibilities with the Care Quality Commission and had reported significant information and events, such as notifications of deaths, serious injuries and any safeguarding issues.

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 Medicines were not always managed in a way that ensured people received their oral and topical medicines at the times they needed them or in a safe way.