Eastgate Care Ltd

Park House

Inspection report

Cinderhill Road
Bulwell
Nottingham
Nottinghamshire
NG6 8SB

Tel: 01159771363

Date of inspection visit:
04 May 2016
05 May 2016

Date of publication:
23 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 May 2016 and was unannounced.

Accommodation for up to 68 people is provided in the home over two floors. The service is designed to meet the needs of older people and has a separate unit for people living with dementia. There were 57 people using the service at the time of our inspection.

At the previous inspection on 3 and 4 June 2015, we asked the provider to take action to make improvements to the area of safe care and treatment, specifically medicines management. At this inspection we found that improvements had been made in this area.

A manager was in post but had not started the application process to become registered with the CQC. The service had not had a registered manager for over a year. 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.

People felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. The premises were well maintained. Sufficient numbers of staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices. Safe infection control and medicines practices were followed.

People's rights were not fully protected under the Mental Capacity Act 2005. People received sufficient to eat and drink, but action had not been taken to ensure that a request for a dietician referral had been progressed for a person who had significant weight loss. Staff received appropriate induction, training, supervision and appraisal. External professionals were generally involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service; however, not all people could use the bath as equipment was not in place to support them to do this.

Staff were caring and treated people with dignity and respect. People and their relatives were involved in decisions about their care. Advocacy information was made available to people. People's privacy was protected and they were encouraged to be as independent as they could be.

People's needs were promptly responded to. Care records provided sufficient information for staff to provide personalised care. Activities were available in the home and plans were in place to improve them further. A complaints process was in place and staff knew how to respond to complaints.

People and their relatives were involved or had opportunity to be involved in the development of the service. Staff told us they would be confident raising any concerns with the management and that the management would take action. There were systems in place to monitor and improve the quality of the

service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe in the home and staff knew how to identify potential signs of abuse. Systems were in place for staff to identify and manage risks and respond to accidents and incidents. The premises were well maintained.

Sufficient numbers of staff were on duty to meet people's needs. Staff were recruited through safe recruitment practices.

Safe infection control and medicines practices were followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights were not fully protected under the Mental Capacity Act 2005. People received sufficient to eat and drink, but action had not been taken to ensure that a request for a dietician referral had been progressed for a person who had significant weight loss.

Staff received appropriate induction, training, supervision and appraisal. External professionals were generally involved in people's care as appropriate. People's needs were met by the adaptation, design and decoration of the service; however, not all people could use the bath as equipment was not in place to support them to do this.

Is the service caring?

Good

The service was caring.

Staff were caring and treated people with dignity and respect. People's privacy was protected and they were encouraged to be as independent as they could be.

People and their relatives were involved in decisions about their care. Advocacy information was made available to people.

Is the service responsive?

Good

The service was responsive.

People's needs were promptly responded to. Care records provided sufficient information for staff to provide personalised care.

Activities were available in the home and plans were in place to improve them further.

A complaints process was in place and staff knew how to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager in place. There had been no registered manager for over a year.

People and their relatives were involved or had opportunity to be involved in the development of the service.

Staff told us they would be confident raising any concerns with the management and that the management would take action.

There were systems in place to monitor and improve the quality of the service provided.

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 4 and 5 May 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist nursing advisor with experience of dementia care 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 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. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted visiting health and social care professionals, the commissioners of the service and Healthwatch Nottingham to obtain their views about the care provided in the home.

During the inspection we observed care and spoke with 10 people who used the service, seven visitors, a visiting healthcare professional, the maintenance person, a domestic staff member, a laundry staff member, the cook, the activities coordinator, four care staff, one nurse, the operations manager, the operations director and the manager. We looked at the relevant parts of the care records of eight people, three staff files and other records relating to the management of the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

During our previous inspection on 3 and 4 June 2015 we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines were not always safely managed. Medicines Administration Records (MAR) for people using the service were not always fully completed. Where medication errors had been made they had not always been identified or reported to management and incident forms had not been completed. Protocols for medicines prescribed for use as required (PRN) were not always in place to give staff information about the purpose of medicines and the circumstances in which they should be administered. Staff were also not always recording the position that they had applied medicine patches to people and people's preferences for how they wanted to take medicines were not always recorded. Documentation for recording when staff had applied creams was not fully completed. At this inspection we found that improvements had been made in these areas and the regulation had been complied with.

People did not raise any concerns regarding medicines and a person told us they received their medicines on time.

We observed the administration of medicines and saw staff checked against the MAR and stayed with the person until they had taken their medicines. MARs had been completed consistently indicating people were receiving the medicines as prescribed. We saw a person had been refusing their medicines for almost a week and staff had contacted their GP to advise them of this and had asked the GP to review the person. When people were receiving their medicines covertly there was a record of the involvement of the GP in the decision. It is good practice to also involve the pharmacist when a decision is made to administer medicines covertly to ensure the medicines remain effective when combined with other substances, but there was no evidence of this in the records.

MARs contained a picture of the person and there was information about allergies and the way the person liked to take their medicines. PRN protocols were in place to provide information on the reasons for administration of medicines which had been prescribed to be given only as required.

Medicines were stored in locked trolleys within a locked room. The temperature of the locations where medicines were stored were monitored daily. However, we saw that topical creams were stored in people's rooms and were not labelled with the date of opening and the storage could be improved. For example we saw some containers without lids and tubes which appeared to have been in use for a lengthy period. This meant that there was a greater risk that the creams might have been used past their effective date.

Staff administering medicines told us and we saw documentation indicating they had had competency checks for medicines administration. They told us they had completed training in medicines administration.

Almost all people told us they felt safe. However, one person said, "Sometimes yes, sometimes no." They explained that on two or three occasions another person using the service had come into their room at night, but they said, "[They] never did harm or say a wrong word." Visitors felt their family members were

safe.

Staff told us they felt people were safe at the service. Staff were aware of the signs and symptoms of abuse and knew how to report any concerns. A safeguarding policy was in place and staff had attended safeguarding adults training. Appropriate safeguarding records were kept.

Risks were managed so that people were protected and their freedom supported.

Care records contained detailed risk assessments advising staff what the risks to a person were and how these risks could be reduced. Risk assessments had been completed for the person's level of risk in relation to nutrition, choking, pressure ulcers, falls and moving and handling. Risk assessments identified actions put into place to reduce the risks to the person and were reviewed regularly.

We saw documentation relating to accidents and incidents and the action taken as a result, including the review of risk assessments and care plans in order to minimise the risk of re-occurrence. Some documentation was not fully completed to show all actions taken in response to incidents. The manager explained that some of the documentation had been recently introduced and more work was being carried out with staff to improve its completion. Falls were analysed to identify patterns and any actions that could be taken to prevent them happening.

Staff said they had sufficient equipment to meet people's needs and we observed staff using moving and handling equipment safely. There were pressure relieving mattresses and cushions in place for people at high risk of developing pressure ulcers and they were functioning correctly. We saw that the premises were well maintained, safe and secure. Checks of the equipment and premises were taking place and action was taken promptly when issues were identified. However, we observed a thickening agent used to thicken fluids for people with swallowing difficulties had been left on their bed table with their drinks. There has been a national safety notice advising how these agents should be stored to restrict access. If these products were consumed they could cause harm.

There were plans in place for emergency situations such as an outbreak of fire. Personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency. An emergency contingency plan was in place to ensure that people would continue to receive care in the event of incidents that could affect the running of the service.

People's views were mixed on whether there were enough staff to meet their needs. A person said, "Oh, yes. Plenty of staff here." Another person said, "Plenty [they're] falling over each other." However, a person said, "Generally enough [staff], however I sometimes have to wait to get washed." Another person said, "No ... have to wait for things." Visitors were generally positive about the amount of staff on duty. Staff we spoke with told us they thought they had enough staff to meet people's needs safely.

We observed that people generally received care promptly when requesting assistance in the lounge areas and in bedrooms. Staff were generally visible in communal areas and spent time chatting and interacting with people who used the service. However, the main lounge was not supervised at times so there was a greater risk that people would not receive a prompt response to a request for assistance.

Systems were in place to ensure there were enough qualified, skilled and experienced staff to meet people's needs safely. The manager told us that staffing levels were based on dependency levels and any changes in dependency were considered to decide whether staffing levels needed to be increased. A staffing tool was

also used to calculate staffing levels. We also checked call bell response times and saw that they were answered promptly.

Safe recruitment and selection processes were followed. We looked at recruitment files for staff employed by the service, including a volunteer. The files contained all relevant information and appropriate checks had been carried out before staff members started work. Staff confirmed this.

Almost all people and visitors told us the home was clean. Staff were able to clearly explain their responsibilities to keep the home clean and minimise the risk of infection. Laundry staff felt that they had sufficient time to complete their work effectively though cleaning staff told us that an additional staff member on duty in the morning would be helpful.

During our inspection we looked at all bedrooms, all toilets and shower rooms and communal areas. All areas were clean and we observed that staff followed safe infection control practices.

Requires Improvement

Is the service effective?

Our findings

Almost all people and their visitors told us that staff were sufficiently skilled and experienced to effectively support them. A person said, "I think they do, as they are very good." A visitor said, "They seem to know what they are doing." We observed that staff competently supported people and interacted appropriately with them.

Staff told us they were given an induction to prepare them for the role. They received two to three days induction and shadowed shifts prior to working independently. Staff told us they were given a variety of training. This included moving and handing, infection control, pressure sores, health and safety and fire safety. Staff told us they had regular support and supervision with the manager but no appraisals. We saw some completed supervisions and documentation showed a wide range of issues discussed by staff.

Training records showed that staff attended a wide range of training which included equality and diversity training. Systems were in place to ensure that staff remained up to date with their training.

People's views were mixed on the quality of food. A person said, "It's very good." Another person said, "Very good, very tasty." However, some people did not like the food. A person said, "Sometimes it's burnt, the veg is soft and horrible. Don't like the sandwiches, the bread is hard."

People told us they had plenty to eat and drink. One person said, "Yes I do. I can have plenty of drink if I want it." Visitors and our observations confirmed this. People's views were mixed on whether they were offered choices at mealtimes. One person said, "Oh yes." However another person said, "No not really."

We observed the lunchtime meal in both parts of the home.

In the dementia unit, we saw that people received their meals promptly and when people needed assistance staff sat with them and helped them without hurrying the person. In the larger part of the home, we saw menus were available and people were offered choices. However, there was a delay between some people being seated and their meal being served. Some people were also then given their dessert while still eating their main course.

Risk assessments had been completed and reviewed monthly to assess people's nutritional risk and care plans were in place giving information about their support needs. A dietary information sheet also provided information about their dietary needs and preferences. Most of the care records we reviewed demonstrated people were maintaining or gaining weight. We saw people were weighed monthly unless they were losing weight when the frequency was increased to weekly. However we saw one person had lost almost 12Kg in weight over the previous five months. Their care plan identified they had a good appetite but had lost weight. While contact had been made with the GP to request a referral to the dietician, this had not been chased by the home in the month prior to our inspection despite the person having lost 5Kg at their last weight at the beginning of April. Charts were in place to record the person's food and fluid intake but the dates on these were inconsistent, and the records, if accurate, indicated the person was not receiving an

adequate fluid intake.

Almost all people and their relatives told us that staff gave them choices and explained what they were going to do before they did it. One person said, "Yes they do explain." Visitors confirmed this. One visitor said, "They do tell [my family member] what's happening." We saw staff asked permission before assisting people and giving them choices. Where people expressed a preference staff respected them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA.

We saw that when people lacked the capacity to make some decisions for themselves; a mental capacity assessment had not always been completed for some decisions and best interests documentation was not always in place.

We reviewed the care records for a person for whom a DoLS application had been made. The person was being prevented from leaving the home and a number of other restrictions were in place to prevent the person from falling as the person had had a large number of falls. A mental capacity assessment had been completed which indicated the person had the capacity to be involved in their care plans whilst another capacity assessment indicated the person did not have the capacity to make a decision about the use of a lap belt when they were in their wheelchair. No other mental capacity assessments had been completed, but a sensor mat was being used to alert staff when the person got out of bed and frequent checks were made of their whereabouts. There was no documentation to indicate the person had consented to this. However, all of the members of staff we spoke to had a good understanding of the MCA and DoLS.

A person whose care records we reviewed had behaviours which others may find challenging. A care plan was in place which described the behaviours but did not provide any clear advice to staff as to the action to be taken by staff and how to calm the person when they became agitated. Another person had attempted to punch staff but their care plan stated, "[Person] shows no signs of behavioural problems." This care plan had not been reviewed following the incident.

We saw the care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. Not all DNACPR forms had been fully completed. The manager told us they would contact the relevant GP to ensure that the forms were correctly completed and the correct processes had been followed.

People told us they were supported with their health care needs. One person said, "Whenever I want I can get to see a doctor." A relative told us that their family member saw their GP on a regular basis.

There was good evidence of the involvement of a range of professionals in people's care as necessary and in most cases referrals had been carried out in a timely manner. These included the dementia outreach team, speech and language therapist, falls team, GP, community nurses and optician.

Where people had wounds or pressure ulcers, wound care plans were in place and wound healing was being

assessed regularly. When people required pressure relieving equipment we saw it was in place and there were records of the person being assisted to move their position in line with the frequency identified in the care plans.

Adaptations had been made to the design of the home to support people living with dementia. Bathrooms, toilets and communal areas were clearly identified, people's individual bedrooms were easily identifiable and there was directional signage to support people to move independently around the home. However, not all communal bathrooms and toilets had signage to show whether the room was vacant or engaged or working locks and equipment was not in place to support all people to use the bath if they wished to.

Good

Is the service caring?

Our findings

Almost all people and their visitors felt staff were kind and caring. A person said, "Overall [the staff are] kind; some kinder than others." Another person said, "Some are very kind, very nice." However one person said, "Not all staff are kind … some are impatient."

We observed staff spoke to people kindly and were patient and understanding. We saw people who used the service were at ease with members of staff and they spoke openly and warmly to each other. We saw a staff member offer comfort and reassurance to a person who was clearly anxious.

Staff were aware of people's support needs and their personal preferences. When we asked two staff members to tell us about a person, they were able to describe a person's care needs, likes and sleeping patterns. One staff member described a person's cultural needs in relation to personal care.

We observed staff providing caring and sensitive support to people. They were patient when a person asked the same question frequently throughout the morning. Some staff spent time engaging with people, particularly in the dementia unit, where people were encouraged to join in some group activities and staff also spent time with people on a one to one basis.

People's views were mixed on whether they had been involved in making decisions about their care. Some people told us they had; most told us they had not. However, people told us that staff listened to them. Some visitors told us that they had been involved in discussions about their family member's care.

There was evidence in care records of the involvement of people and/or their relatives in the development and review of their care plans. Care records contained information which showed that people and their relatives had been involved in their care planning. Care plans were person-centered and contained information regarding people's life history and their preferences. Advocacy information was also available for people if they required support or advice from an independent person.

Where people could not communicate their views verbally their care plan identified how staff should identify their preferences and staff were able to explain this to us. A person's ability to communicate verbally had been affected by a health condition. A communication care plan was in place which identified ways to support the person to communicate their views. The person had received regular input from a speech and language therapist and there were several copies of a visual communication book to assist them to communicate. We saw there was a copy in the person's bedroom and in the lounge where they sat.

People told us that members of staff respected their privacy and dignity. Two people told us staff always knocked on their bedroom doors before entering. A relative agreed and told us when they once tried to enter their family member's bedroom they were asked to leave as staff were involved in personal care. The relative agreed with this decision.

Staff were able to describe how they respected people's privacy and dignity. Staff told us they made sure

doors were shut during personal care, or when talking with other professionals. They also told us that care plans were not left out in the open and were locked away and they talked to people quietly about sensitive issues such as going to the toilet.

We saw staff protecting people's privacy and dignity when they were being moved using a hoist and providing lots of reassurance. Staff were able to describe the steps they took to protect people's privacy and dignity when they were providing care. We saw that staff treated information confidentially and care records were stored securely. The language and descriptions used in care plans showed people and their needs were referred to in a dignified and respectful manner.

People were supported to eat their meals independently; adapted cutlery and plates were used by some people. A staff member described how a person who used the service helped them give drinks to people. A visitor told us their family member was encouraged to be independent by staff.

People told us their relatives were able to visit them whenever they wanted to. Relatives confirmed this. We observed relatives visiting their family members throughout the inspection. One person said, "Whenever they want, they can come at night."

Good

Is the service responsive?

Our findings

People received care that was responsive and personalised to their individual needs, preferences and what was important to them.

We saw a staff member offered lunch early for a person who was asleep for most of the time and a drink as soon as they woke up. A staff member told us this happened due to this person's poor sleeping pattern, which was confirmed by the person's relative.

Care plans were in place to provide information on people's care and support needs. These provided clear instructions for staff on the support the person required and their individual preferences. They had been reviewed monthly and had been updated in response to changes in the person's condition. For example, when a speech and language therapist or community nurse had reviewed people and given advice on the best way to manage the person's health needs, the advice was incorporated into the person's care plan.

The Alzheimer's Society's 'This is me' booklet had been completed for some people and provided brief information about their life, relationships and preferences. In addition, we saw a person's family had provided some detailed information about their life history and this was available within the care record. We saw that the care plans for a person with diabetes provided information for staff on the management of the condition and the steps to take if the person's blood sugar levels were lower or higher than the normal range.

Care records contained information regarding people's diverse needs and provided support for how staff could meet those needs. We spoke with a visitor whose relative's first language was not English. They told us that some staff used their relative's first language to communicate with them. A person told us that while they did not object to care being provided by male staff they did not want male staff to wash them and they told us that their choice was respected.

A visitor felt that their family member's condition had improved due to the activities they were involved in, including playing dominoes. Another visitor told us they had seen activities such as drawing, and dogs and ponies have been brought into the home.

People were engaged in many activities on the dementia unit. People were having their nails done, playing catch with a ball, reading newspapers, playing skittles and staff members were dancing and encouraging people to move their bodies whilst sitting. In the other part of the home, we saw a session of war time reminiscences with artefacts was followed by a musical session led by activities co-ordinator. More than a dozen people who used the service took part. The activities coordinator encouraged people effectively to take part in the activity.

There was an advertised activity twice a day, seven days a week. The activities co-ordinator came in one or two weekends a month to support other staff running activities at that time. The activities coordinator had made significant improvements in the level of activities taking place at the home and planned to improve

the range of activities further.

People's views were mixed on whether they knew who to complain to. A person told us they would "shout at" whoever was close to hand. Another person told us they would speak with care staff but said, "A waste of time. Always promises- nowt happens." However a visitor said they would contact the manager directly. Another visitor told us they were comfortable raising concerns with the manager, who had been receptive to their concerns. Staff were able to explain how they would respond to complaints.

A recent concern had been handled appropriately. Guidance on how to make a complaint was in the guide for people who used the service. There was a clear procedure for staff to follow should a concern be raised.

Requires Improvement

Is the service well-led?

Our findings

A manager was in post but had not started the application process to become registered with the CQC. The service had not had a registered manager for over a year.

Some people and visitors were aware of meetings for people who used the service and their families. A person said, "There's plenty, but I've never been." Meetings for people who used the service and their relatives took place and actions had been taken to address any comments made. There were notices displayed in the home to inform people and their relatives of the upcoming dates for the meetings.

We saw that a range of surveys were completed by people who used the service and their families. Responses were positive and actions were taken in response to any identified concerns. There were notices displayed in the home to inform people and their relatives what action had been taken in response to their comments.

A whistleblowing policy was in place and contained appropriate details. Staff told us they would be comfortable raising issues using the processes set out in this policy. The provider's values and philosophy of care were in the guide provided for people who used the service. A visitor told us that the staff were accommodating and the home was, "Pleasant and inviting."

Staff we talked with were committed to their job and demonstrated their care for people. One staff member said, "Staff are brilliant. We all get on, we are a team." Another staff member said they felt there had been significant changes at the service since the last inspection and they felt proud of the improvements which had been made. They said, "Everything has changed. Everybody has been working so hard." A visiting professional told us that there had been significant improvements in the home.

People and visitors felt they could speak to the manager and she was approachable. A person said, "Yes, I have spoken to her before." Another person said, "Yes you can come in here [manager's office] and speak to them." Another person said, "[Management] listen all the time, they are very good."

Staff told us they felt the leadership of the home was good. People and staff were positive about the manager. A staff member told us, "The manager is absolutely lovely. She's brilliant and will tell you anything you need to know." Another staff member said, "The manager is lovely and approachable. She deals with things straight away." Another staff member told us they had confidence in the manager and said they received excellent support from her. They went on to say that as the manager was a nurse she understood the issues they raised and was able to address them or provide them with the necessary guidance.

Staff told us they had staff meetings every month. We saw that regular staff meetings took place and the manager had clearly set out her expectations of staff. Staff told us that they received feedback in a constructive way.

A manager had been in post for ten weeks and she clearly explained her responsibilities and how other staff

supported her to deliver good care in the home. She felt well supported by the provider. She told us that sufficient resources were available to her to provide a good quality of care at the home. We saw that all conditions of registration with the CQC were being met and statutory notifications had been sent to the CQC when required. The current CQC rating was clearly displayed in the main reception area of the home.

The provider had an effective system to regularly assess and monitor the quality of service that people received. We saw that regular audits had been completed by the manager and also by representatives of the provider. Audits were carried out in a range of areas including infection control, care records, medication, health and safety, mealtimes and catering. Action plans were in place where required to address any identified issues. Night time visits were also carried out to check the standard of care provided at night.