

Monarch Consultants Limited

Parkside Nursing Home

Inspection report

Olive Grove
Forest Town
Mansfield
Nottinghamshire
NG19 0AR

Tel: 01623655341

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 14 June 2016 and was unannounced.

Parkside Nursing Home provides accommodation for up to 50 older people with varying support needs including nursing and people living with dementia. On the day of our inspection there were 29 people living at the home.

Parkside Nursing Home is required to have 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 the time of our inspection a registered manager was in place.

We carried out an unannounced comprehensive inspection of this service on 6 and 7 April 2016. We issued a warning notice to the provider. People had experienced incidents of avoidable harm because the provider had not appropriately assessed how risks to people were monitored and mitigated. We also identified concerns relating to how records of people's care and treatment were completed, monitored and maintained.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the warning notice. We found at this inspection that the provider was compliant with the warning notice.

Improvements had been made to the systems and processes that assessed, managed and monitored quality and safety. People's individual needs were assessed and care plans and risk plans were in place to advise staff of how to meet people's needs. People had the required equipment in place to reduce risks from occurring and people's records were completed accurately and were maintained appropriately.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

The service was not consistently well- led.

We found that action had been taken to improve how risks to people's needs were assessed, managed and monitored. Record keeping had improved; people's care records had been appropriately maintained. Improved quality assurance systems and processes had been implemented.

Whilst improvements had been made we have not revised the rating for this key question; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

We will review our rating for well-led at the next comprehensive inspection.

Requires Improvement ●

Parkside 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. We undertook an unannounced focused inspection of Parkside Nursing Home on 14 June 2016.

This inspection was completed to check that improvements to meet legal requirements in the warning notice had been made.

The inspection team consisted of one inspector who inspected the service against one of the five questions we ask about services: is the service well-led. This is because the service was not meeting some legal requirements in relation to that question.

During the inspection we spoke with one visiting relative. People were not able to tell us about their experience of using the service. This was because people affected by the warning notice were living with dementia. We spoke with the registered manager, regional manager, deputy manager and care supervisor. We looked at records in relation to care records for six people who used the service as well as a range of records relating to the running of the service. This included records of associated quality assurance processes.

Is the service well-led?

Our findings

At our last inspection of the service we identified a breach with Regulation 17 Good Governance (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A warning notice was served on the provider. Following the inspection the provider sent us an action plan detailing what they would do to meet the required improvements. At this focused inspection we found the provider had met their action plan and the breach in Regulation 17 described as above.

A visiting relative told us they were satisfied with how their family member was cared for. They told us, "Risks are always there but what's important is how they are managed. I find the staff can tell me how [name of family member] is, I ask different staff and they always know. They do their best to keep them safe." They also said, "I visit every day and often look at the daily records to see what [family member] has eaten and been up to. I've noticed staff are recording more detailed information."

We spoke with a care supervisor who said that positive changes had been made since our last inspection. They said that this included improved record keeping and systems to monitor care records to check these were kept up to date. They also said that staff were more vigilant and took greater responsibility for maintaining a safer environment for people.

The provider had improved the pre-assessment process before people moved to Parkside Nursing Home. The registered manager told us of the actions they completed before a person moved to the service. This included an holistic assessment of a person's needs. The deputy manager showed us an end of life care plan, and daily record chart that had been introduced since our last inspection. This told us that people's needs had been appropriately assessed, planned for and accurate and complete care records were kept up to date.

We looked at six people's care records and found that risks associated to people's needs had been assessed and risk plans were in place. Where equipment had been identified as required to reduce known risks we found this was in place. For example, some people were at high risk of falls. A sensor mat was in place for some people to alert staff if they had got out of their bed. A floor mat referred to as a crash mat, was available for other people and bed sides with padded protection were available to protect people from injury. Some people used catheters and we found care plans and risk assessments had been completed to advise staff in the management of catheter care.

Risks associated to people's dietary and nutritional needs had been assessed and planned for. New information records had been introduced for kitchen staff to inform them of people's needs. We looked at four people's care records who had specific needs associated to their dietary needs. For example, some people had been assessed as being at risk of choking and required a soft or pureed diet. Records available to kitchen staff reflected information in people's care records. This told us that communication within the service had improved and people could be assured their needs were known and understood.

Since our last inspection the provider had purchased new scales to monitor people's weight. The registered

manager told us that every person who used the service had had their base line weight recorded. The registered manager also advised that new records used to monitor people's weight had been introduced. Records confirmed what we were told. The deputy manager gave an example of the action taken due to changes with a person's weight. This included contact with the GP and working with the dietician. This meant that people's weights were being effectively monitored and appropriate action was taken when concerns were identified.

We checked the clinical equipment in place. One piece of equipment was new and we found other equipment such as a blood pressure monitor were all fit for purpose. The registered manager told us that visual checks by the nursing staff of this equipment were completed daily but they were in the process of introducing a formal procedure to record these checks.

We found improvements had been made to the management of medicines. This included an electronic system whereby nursing staff were alerted four days in advance of when a person required a repeat prescription. The deputy manager showed us how another new process had been implemented that did a daily stock check of medicines. We reviewed people's care plans for medicines prescribed to be administered as and when required. Whilst we found these were in place they were limited in detail. We discussed this with the registered manager who agreed and said that they would take immediate action to address this issue.

The regional manager told us of the audits that had been introduced since our last inspection that checked on quality and safety. These included detailed checks the registered manager did on a daily basis. This included checks on staffing levels, care records and the environment. The registered manager also showed us how they were in the process of implementing a system that monitored accidents and incidents. The registered manager said that this would enable them to have oversight of any themes and patterns to enable them to consider lessons learnt and action required.

We looked at the accidents and incident records and found that there were few accidents and appropriate action had been taken to reduce further risks. We spoke with a visiting relative whose family member had been involved in some recent falls. They told us that they felt appropriate action had been taken and that they had been involved in discussions and decisions of how these risks were managed.