Valley Park Care Centre (Wombwell) Limited

Parkside Care Home

Inspection report

Park Street
Wombwell
Barnsley
South Yorkshire
S73 0HQ

Tel: 01226759371

Date of inspection visit:
08 December 2017
14 December 2017

Date of publication:
15 February 2018

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**

Summary of findings

Overall summary

This inspection took place on 8 and 14 December 2017 and was unannounced. This is the first inspection of Parkside Care Home.

Parkside Care Home is registered to provide care for a maximum of 36 people. The management team told us 23 people were using the service when we inspected. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a 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.

The provider's systems and processes did not enable them to effectively assess, monitor and improve the service. They did not effectively monitor and mitigate risk. Checks were not always carried out to make sure the premises and equipment were safe and comfortable to use. Bathrooms and some toilets had no heating. People did not receive regular baths and showers.

People's care plans varied in quality. We saw some had good information about people's preferences, likes and dislikes, however, we also saw there was sometimes a lack of guidance and evidence that appropriate care had been delivered. Risk assessments covered key areas of risk but were not always effective.

We observed many positive and kind interactions between staff and people who used the service. People were comfortable in the company of staff and others they lived with. Staff knew people well and were familiar with their routines and preferences. Staff obtained verbal consent from people before delivering care. However, we also saw two occasions where staff were not focused on the people they were supporting because they were talking to each other. Staff referred to people as 'singles' and doubles'.

A choice of meals was provided although this was limited; the alternative main meal was a snack type meal such as jacket potato, soup and sandwiches, chip butty or salad. People received regular snacks between breakfast, lunch and teatime, however, we saw people who got up early had to wait two hours before they received a drink. The service did not have an activity worker which meant person centred activities and social stimulation was not being provided on a regular basis.

People told us they were happy living at Parkside Care Home. Everyone we spoke with said staff were friendly and kind. People we spoke with said they would feel comfortable talking to staff or the registered manager if they had concerns.

At the time of the inspection there were enough staff to keep people safe; the provider was introducing a dependency tool to help calculate staffing requirements. Staff received training and support to help them

understand their role and responsibilities.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014: The provider was not always assessing and managing risk: The provider's systems and processes did not enable them to assess, monitor and improve the service. The provider did not ensure the care people received was appropriate. The provider did not ensure people's nutritional needs were met. You can see the action we have told the provider to take at the end of this report.

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 service was not safe.

The provider did not ensure the premises and equipment were safe to use. Risk to people was not always assessed and managed.

There were enough staff to keep people safe although some people said they sometimes had to wait for assistance.

Systems were in place to manage medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and support to help them understand their role and responsibilities.

People were asked to give their consent to their care and support.

People were offered a choice at meal times, however, the variety of food was limited, and a lack of monitoring meant people's diet might not be nutritionally balanced. People's health needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

People who used the service and relatives told us staff were kind and caring although on to occasions staff did not focus on the people they were supporting.

Staff knew people well. We observed mainly positive and caring interactions.

Information was available to help keep people informed about what was happening in the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive person centred care. Guidance for staff and records around delivering care varied.

There was a lack of person centred activity and social stimulation.

People were comfortable raising concerns. A system was in place to record and respond to complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

The registered manager was knowledgeable around most aspects of the service but was unsure about some areas that were relevant to their role and responsibilities.

The provider's quality management systems were not always effective and did not always identify areas where the service had to improve.

People who used the service and relatives had opportunity to share their views but these were not always used to drive improvement.

Parkside Care 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.

Before the inspection we reviewed all the information we held about the service including statutory notifications. We contacted relevant agencies such as the local authority, clinical commissioning group and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. The provider had completed a Provider Information Return (PIR) in June 2017. 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. At the inspection we asked the provider for information which was more up to date where relevant.

This inspection took place on 8 and 14 December 2017and was unannounced. On day one, two adult social care inspectors, an inspection manager and an expert-by-experience carried out the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two, two adult social care inspectors carried out the inspection.

During the visit we looked around the service and observed how people were being care for. 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. We spoke with eight people who used the service, five visiting relatives and a visiting health professional, five members of staff and two members of the management team which included the registered manager. We spent time looking at documents and records that related to people's care and the management of the home. We reviewed four people's care plans.

Inadequate

Is the service safe?

Our findings

At the inspection we found the provider did not ensure the premises and equipment was safe. We looked around the service and noted a number of issues had either not been identified by the provider or had been identified but not addressed. The service had two bathrooms and a shower room. Both bathrooms and some toilets had no heating and were very cold. The bathrooms had heaters; one did not work and the other smelt of burning when we switched it on. The registered manager said staff did not use it.

The service had storage heaters. We saw one heater had been switched off; the wooden heater cover was damaged and blackened from the heater. A member of staff told us the top of the cover had been replaced because it was badly burned. Another heater and cover was very hot and it was evident this was not safe. There was no evidence to show the heaters had been checked by a competent person. The registered manager arranged for an engineer to attend the same day and they condemned both storage heaters. Other heaters in the home were assessed as safe to use.

We noted the lift floor did not sit level with the exit so was a trip hazard. We saw this had been highlighted by the lift engineer in July 2017 and reported by the registered manager to the provider in October 2017 and reported as 'dangerous'. However, no action had been taken to rectify the problem. We were told there had been a problem with the main cooker and a replacement second hand cooker had been brought into the service the day before the inspection. We requested to look at documentation to confirm this had been serviced but were told by the registered manager this was not available. The registered manager instructed staff that the cooker was not to be used until the contractor had carried out a service. They confirmed a service was completed the day after the inspection and no issues were noted.

Fire exits should be kept clear so people can evacuate easily and safely in the event of a fire. We saw four cardboard boxes were stored next to a fire exit which would cause a hazard. The registered manager arranged for these to be removed straightaway.

We saw the service had a call system which when activated alerted staff that assistance was required. However, call activation points were not easily accessible, and only five bedrooms had hand held devices. One person raised a concern with us. They said, "The other night I had to wait about an hour and a half. The staff said they were sorry. They had not heard my alarm." This person had a hand held device. Staff we spoke with said they were unclear what happened but understood there had been an incident. There was no record of the incident which the registered manager agreed to follow up. They said it was possible the hand held device was faulty. They also said limited activation points and hand held devices were recognised as issues and they were planning to replace the call bell system.

We saw emergency light monthly checks had been carried out by the provider. It had been recorded for over nine months that emergency lights were not working when the power was turned off. We raised this concern with the registered manager. They arranged for additional torches to be situated around the building and told us staff had been informed where they were located. The registered manager took action in response to environmental issues, however, we concluded the provider did not ensure the premises and equipment was

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

We saw some premises and equipment checks were effective. For example, we saw firefighting equipment was serviced and a gas safety check and electrical installation check had been completed. Internal records showed regular fire drills, weekly fire safety tests and monthly wheelchair visual checks were carried out.

All cleaning materials were kept safe and throughout the service we saw equipment was available to manage the control and prevention of infection such as hand soap and paper towels. Staff told us they had access to disposable protective clothing such as gloves and aprons.

The home looked clean. However, we noted in bathrooms and toilets infection control standards were not met because surfaces could not be appropriately cleaned. For example, a bath was chipped and a bath hoist was rusty. Paint on pipework was flaking and some tiling was not appropriately sealed. We concluded the provider did not assess the risk of and take action to control the spread of infection. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people had risk assessments in place for areas such as nutrition, falls, moving and handling, fragile skin, behaviour that challenged and choking. However, some assessments were not effective. For example, we saw food and fluid charts for one person gave no fluid targets and had not been evaluated. Therefore the provider could not evidence that the person was drinking sufficient amounts of fluids to keep them hydrated. One night care worker told us this person frequently had restless nights and would take a few sips of drinks. The food and fluid charts did not show how much people drank throughout the night as the record stopped at supper time.

The person's weight record showed they had lost weight and food charts indicated they were not receiving adequate nutrition. For example, on 6 December 2017 it was recorded they had no food throughout the day and had only eaten biscuits at supper time, and on 7 and 8 December 2017 they had not eaten breakfast. Staff told us that they did not disturb the person if they were asleep but did not provide additional food at other times. This meant the provider could not be sure the person ate sufficient amounts of food to meet their nutritional needs.

We saw the person had been referred to their GP due to behaviours that challenge. Staff were asked to record behaviours on a chart so health professionals could identify any triggers. The records were completed inconsistently, and therefore it would be difficult to develop an appropriate behaviour management plan.

We looked at another person's records which showed inconsistencies in pressure prevention. Some records said the person should change position every four hours whilst in bed; others stated two hourly. Records stated repositioning whilst in the lounge was two hourly. However, we saw the person was sat in the lounge at 7am; night staff told us the person had been seated since 6.30am. At 9.40am the person was taken to their bedroom to have their personal needs met. This meant they had not changed their position for 3 hours and 10 minutes. We looked at the daily records for this person and found the record for the 12 December 2017 only recorded one change of position from 9am through to 3.40pm. On 13 December we saw the daily record stated, "Assisted with pressure care at 3pm" and the next entry relating to pressure care was at 7.30pm. This meant the person had not received the care and treatment they required.

We saw this person was weighed monthly. Relatives raised a concern with us because they felt the person had lost weight. We asked staff to weigh the person and records confirmed this. Since September 2017 they

had lost 3.3kg. Staff told us the person was not monitored for their food and fluid intake as they had not been identified as nutritionally at risk. The registered manager agreed to put records in place to monitor any further weight loss. We concluded the provider did not assess and manage risks to people who used the service. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood safeguarding procedures and knew they should report any concerns to the management team. They were confident any concerns would be acted on promptly. A member of staff told us, "I feel really confident about protecting people and I know we have a whistle blowing procedure." Training records we reviewed showed staff had received safeguarding training. The registered manager told us there were no open safeguarding cases at the time of the inspection.

People who used the service, visiting relatives and friends told us people were safe living at Parkside. Comments included, "I do feel safe here", "The staff are grand. They do all they can to make you safe", "Oh yes, I am so grateful to be feeling safe", "[Name of person] is so much safer living here, far safer than when she lived at home".

Although people said they felt safe some people raised concerns around the staffing arrangements. Comments included, "They do get short of staff at times", "The staff do all they can for you but sometimes they are run off their feet", "Sometimes I have to wait a long time when I use the nurse call. They are busy helping other people", and "Sometimes there are not enough staff. It's just an observation".

We reviewed four weeks staffing rotas which showed staffing levels were consistent. Five care workers were employed between 8am and 2pm; four care workers were employed between 2pm and 8pm; three night workers were employed between 8pm and 8am. A senior care worker or team leader was always on shift and included in the care team numbers. During the inspection we noted that there were sufficient staff to meet people's needs. People did not have to wait when they requested assistance.

Staff we spoke with did not raise any concerns about the staffing arrangements. The registered manager told us they were confident there was enough staff. They said, "I observe, and go out on the floor. At busy times I assist and ancillary staff also provide support." They told us they did not use a dependency tool to help calculate staffing requirements but showed us a tool the provider was introducing and due to commence the week after the inspection. This would help ensure the staffing arrangements were appropriate. We checked four staff files and saw the provider followed a robust recruitment process and carried out the necessary checks before staff commenced work.

We reviewed how the provider was managing medicines and found appropriate systems were in place and people received their medicines as prescribed. People told us they got their medication on time. One person said, "I get my medication just when I need it." Another person said, "They are good at making sure I get my painkillers." A visiting relative said, "[Name of relative] takes regular pain killers. She always gets them on time when I am here and I visit at different times."

We looked at the storage, handling and stock of medicines and how the administration of medication was recorded. Medicines were stored safely, at the right temperatures, and records were kept for medicines received and administered.

Staff who were responsible for administering medication had received training. We also found periodic competency checks were carried out to make sure staff were working to expected standards. We observed staff administering medication to people who used the service. They did this in a safe way that reflected

good practice guidance, such as confirming medicines had been administered.

Staff were able to explain to us the signs to look for when people were in pain or distressed to ensure they received their prescribed medication when required. We found people had protocols in place for medicine that was prescribed on an 'as and when required' basis. These explained how people presented when the pain relieving medication was required. These assisted staff in identifying when to administer.

We checked the controlled drugs (CD's) held for people who used the service. CD's are governed by the Misuse of Drugs Legislation and have strict control over their administration and storage. We looked at the controlled drug record for one person and found the record for the previous night had only one signature. The record required another member of staff to witness the medication being administered. We also found a supply of medication used for pain control for one person was in the CD cupboard. However, the medication had been discharged in the CD record. The senior care worker told us the medication should have been collected by the supplying pharmacist. We brought this to the attention of the registered manager for her to investigate the omission.

Monthly audits were undertaken to ensure any errors or mistakes were addressed and actioned quickly. The quality assurance manager also reviewed the medication procedures and produced an action plan where needed. We were shown evidence that any issues identified had been actioned.

The registered manager was responsive when we identified issues relating to quality and safety. They also discussed how they used complaints, concerns and general feedback to learn lessons and improve their systems and processes.

Requires Improvement

Is the service effective?

Our findings

At lunch we saw people were offered a choice of meal. In the dining room, condiments, jugs of water and juice were on the table and people helped themselves to drinks; staff assisted when appropriate. A number of people chose to eat their meal in their room. Staff showed people plates of food to help ensure they could choose the meal of their liking. However, we also saw one person asked if they could have sausage, egg, chips and beans. Staff ignored the request and showed the person the plate of fish finger, chips and peas. After showing the plate to the person twice they said they would eat the fish fingers. Staff did not explain to the person that sausages were not available or give reassurance they could have these another time. We also heard the person request sausages at breakfast. People were offered a range of snacks and drinks throughout the inspection. However, on 14 December 2017 when we arrived at 7am, we observed some people had to wait to receive a drink and their breakfast. Six people were dressed and in the lounge. Staff told us some people had started getting up at 6.20am but drinks and breakfast were not served until 8.20am

We received a mixed response when we spoke to people about meals. Comments included, "The food is very nice", "I really like the food. I have no complaints", "I have my meals in my room. It's cold most of the time", "There is always a good choice", "The range of diabetic desserts are not very good", "Sometimes it is cold" and "I like all the food. The cooks will do you anything really". A relative told us, "I often come at mealtimes and the food seems lovely." Another relative said, "They offered me a meal. It was lovely"

Menus were displayed and followed a four week rota. We saw a choice of meals was provided although this was limited. We noted the main meal included options such as shepherd's pie and pork cobbler but the alternative main meal was often a snack type meal such as jacket potatoes, soup and sandwiches, chip butty or salad. Menus included the main dish but there was no detail of any vegetables that were being served as an accompaniment. We visited the service on a Friday. The meal option was displayed on a large board in the dining room; people had the choice of fish fingers, chips and peas or chip butty or ham salad. We saw fish dishes such as fish cakes and scampi were offered every Friday but people were not offered fish. The registered manager agreed to review the menus.

We looked at individual food charts which were all kept in one file. We found these were not completed with sufficient detail. For example, staff had recorded 'eaten full dinner' but the meal option was gammon or cheese sandwich. This meant when assessing if people had nutritionally balanced meals staff would not know if the person had eaten a snack or main meal. We concluded the nutritional needs of people who used the service were not met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with understood their roles and responsibilities around caring and supporting people who used the service. We observed staff attending a handover delivered by the senior care worker at the beginning of the shift. This provided attendees with information about people's health and wellbeing. Staff made notes of people who needed extra observations. For example, the senior care worker told staff that one person who used the service required additional fluid and food because they had not eaten very well and had refused drinks. The senior care worker also described another person as quite sleepy because they

had not slept very well the previous night. Staff were told to observe this person and suggested bed rest.

Staff told us they were happy with the training on offer. They said this gave them the skills and knowledge to do their job well. The registered manager and provider had a system in place to monitor staff training to ensure essential training was completed each year. Training included basic life support, safeguarding, equality and diversity, food safety, moving and positioning, person centred care, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), health and safety, infection prevention and fire awareness. The registered manager told us new starters completed the 'Care Certificate' which is an identified set of standards workers adhere to.

Staff we spoke with confirmed they had regular opportunities for formal supervision and had also attended staff meetings. They said they felt supported by the registered manager and colleagues. Most felt their concerns were listened to. We reviewed four staff files and saw they had all received at least four supervisions in 2017; three had received an annual appraisal. The registered manager told us 25 out of 30 appraisals were completed and the remaining five were booked. A supervision overview was not available for 2017. A blank supervision matrix was displayed on the notice board; the registered manager confirmed this would be completed in 2018.

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 so that they can 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 Deprivation of Liberty Safeguards (DoLS).

The registered manager maintained a DoLS tracker. We saw this identified when DoLS were authorised and where they were waiting for authorisation. The registered manager had liaised with the local authority regarding the status of applications. We looked at an authorised DoLS for one person. This had conditions relating to any changes in the person's care and treatment, including compliance around medicine administration; staff we spoke with were aware of these and confirmed practices met the conditions. The registered manager also maintained a list of relatives and friends who had power of attorney. This ensured when people no longer had capacity to make decisions their appointed representative was recognised to make decisions on their behalf.

In the PIR the provider told us they completed assessments prior to people moving into Parkside Care Home. They said, 'We also take into account the person's capacity to make decisions about their care needs, in line with the MCA. If a resident lacks the capacity to make formal decisions for themselves this will be identified at the assessment and a multi-agency team will become involved in this person's best interests.' Records we reviewed confirmed this.

Staff we spoke with were confident that where possible people made their own decisions. Staff also understood that decisions had to be made in the person's best interest when they did not have capacity.

Throughout the inspection we saw people were offered choices and staff obtained verbal consent before delivering care. For example, staff checked people were okay and asked what they would like to do. They asked permission before entering people's rooms.

We found people's health needs were met. Care records showed people had access to a range of health care

professionals such as GPs, community nurses, dieticians and opticians. Staff contacted emergency services as required and used the out of hours call centre for advice. Records were made when other professionals visited and any treatment or advice they provided. We spoke to a visiting district nurse who said, "Things have improved here recently. We did have issues when staff were not following treatment plans but they are much better now. I have no concerns about the care provided and staff notify us if they have concerns about someone." They went on to give an example. They said, "They have asked me to look at a person who had fallen during the night. I have and they are fine." They told us staff had a good understanding of the signs and symptoms that would alert them to a person whose health had deteriorated.

Relatives confirmed staff contacted health professionals when required. Comments included, "The staff are very good at contacting the GP if they have any concerns, they also let me know if a GP has visited my [family member] and if any treatment is required", "She always gets to see the district nurse" and "When Mum was not well they kept me informed of everything".

When we looked around the service we found some areas were well decorated; however, we also saw some areas needed decorating. Relatives raised some concerns about the environment and felt the general decoration should be improved. Comments were made about poor quality carpets. One relative said, "Some bedroom floor coverings are worn, stained and dirty". Another relative said, "The home upstairs looks untidy these days." The registered manager told us they did not have a formal decoration plan but were improving the environment which included making it 'dementia friendly'. For example, they had painted hand rails a contrasting colour which can help navigation. They said they were looking at providing more environmental stimulation. After the inspection the provider sent us a very basic decoration plan which showed several areas would be decorated in January 2018. Information around making the service more suitable for people with dementia was not included.

Communal areas were provided on the ground and first floor although the ground floor was the only area that was generally in use. People had access to an enclosed outdoor area which had a seating area.

Requires Improvement

Is the service caring?

Our findings

People told us the staff were kind and caring. Comments included, "The staff are good; they look after me well", "The staff always seem happy and upbeat", "The staff are so kind and patient. They have a very hard job with some people", "The staff are so good to us", "The staff are wonderful. They go to so much trouble", "You couldn't want for better staff to look after you", "The night staff are lovely" and "The helpers who look after me are wonderful".

Visiting relatives also told us people were well cared for and were complimentary about the staff. Comments included, "The staff know my mum so well", "My mum responds really well to all the staff", "Me and my brother are sure mum is well cared for", "Staff are very good and they are attentive.", "The staff are very friendly, caring and approachable, but busy", "She couldn't receive better care" and "One of the family comes every day so we get a good idea of what's going on. The staff are great". Relatives and friends told us they felt welcome when they visited Parkside.

During the inspection we observed many positive and kind interactions between people and staff. People were comfortable in the company of staff and others they lived with. There was lots of laughter and friendly exchanges between staff and people who used the service. At lunch we saw staff were caring when people needed encouragement to sit at the dining tables. Some people left the dining area during the meal, and staff encouraged them patiently and calmly to return to finish their meal. Staff knew people well and were familiar with their routines and preferences. Staff spoke about people with respect and affection.

Staff we spoke with were confident people received good care. They gave examples of how they promoted people's independence and dignity. One member of staff said, "We encourage people to do things for themselves, like getting dressed and offer help when they need it." We observed that staff respected people's privacy by knocking on doors and calling out before they entered their bedroom or toilet areas.

Although we observed mainly positive interactions we saw two occasions where staff spoke to other staff rather than the person/people they were supporting. Staff also routinely referred to people as 'singles' and 'doubles' rather than referring to them by name. One person was being assisted by two staff to stand from the chair. We saw both staff speak to each other over the top of the person's head. At lunch two staff were assisting people to eat in the lounge area. They talked to each other across the room and discussed 'rotas' and 'family matters'. This meant people were not treated with respect and did not receive person centred care.

When we looked around the service we saw there was information displayed around the service which helped to keep people informed. Menus were displayed and the daily menu board was updated accordingly. There were notices and leaflets around dignity, how to make a complaint, infection control and safeguarding. An activity plan was displayed, however, this did not always reflect the activities provided. The registered manager said they were going to introduce more pictorial information and signage around the service to help ensure this was suitable for people with dementia. Care records were stored securely which ensured confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

People who used the service and relatives told us they were happy with the care they received at Parkside Care Home although not everyone said they felt involved in the care planning process. One relative told us they were visiting to read and agree their family member's care plan.

We reviewed care records and saw these varied. We saw people had a 'this is me' document, which contained information about their history, preferences, likes and dislikes. Preferences included people's end of life wishes. Some people's records had much more information than others. Family members had provided some of the relevant detail and accounted for some of the variation. The registered manager and staff talked about an example of a very comprehensive 'booklet' that had been completed by a relative and described the person's history and needs. One member of staff said, "It is a fantastic document. I have found it so helpful in developing a great care plan." They told us everyone would benefit from having something similar.

Care plans generally contained information that identified how people's needs should be met, however, we noted one person's moving and handling care plan was not up to date so the guidance was incorrect. Another person's care plan stated they liked to get up between 7am and 8am, however, staff told us that they did not wake the person until much later. We observed the person was supported to get up at lunchtime.

Care records were inconsistent and did not always evidence whether appropriate care had been delivered. For example, repositioning charts, and food and fluid charts did not evidence people received appropriate care. Daily records were not always specific, for example, it was not clear when people were going to bed or getting up. One person said, "They do start getting us up quite early. They get me up about 6.30am." It was not possible to establish from the records what time the person had been getting up in a morning and concluded the person did not receive person centred care.

When we visited on 14 December 2017 we asked to look at recent night check records. We saw they had not been completed for the ground floor on 13 December and had not been completed for the first floor on 11 December 2017. This meant there was no evidence appropriate care was delivered.

Records and feedback indicated most people did not receive regular baths or showers. Two people had daily showers, however, there was very little information in care records about others having baths and showers. We were shown a file which recorded when people had baths or showers. We looked at 18 people's records on 8 December 2017; six people had not had a bath or shower in November and 11 people had not had a bath or shower in December. A night staff member told us they regularly showered two people when they got them up in the morning but did not assist others. One person who had been at the service for five months said, "Although the staff ask you what you need I have only had two showers since I came here. The shower room is upstairs." One member of staff told us, "The bathrooms are very cold so people don't want to bathe. Yesterday two people said they were cold and didn't want to get changed." We showed the registered manager the records and they agreed there was very little evidence people were having a bath or

a shower. When we visited the service on 14 December 2017 a new bath/showering record had been introduced. The registered manager said they would be closely monitoring these.

Some information was confusing and could result in a person receiving inappropriate care and treatment. One person's care records stated in October 2017 the district nurse had been asked to look at a pressure area on the person's heel, ankle and the side of their foot. We spoke with a visiting district nurse who informed us the areas had healed successfully. This was a positive outcome, however, the person's care records did not reflect this because staff had not recorded that treatment was no longer required. Another person had a treatment record for eye drops, however, we found this was no longer in use but the record did not reflect this.

One person told us, "I wear glasses but I don't know where they are." Another person said, "I should be wearing my glasses. I haven't seen them lately." Two relatives told us they had concerns about their family member losing their glasses which were prescribed to help them see better. We saw in an office a number of pairs of glasses; some had names on so they could be returned to the person; others were unmarked. A care worker told us people put their glasses down and then forgot where they had left them. Staff agreed to return as many glasses to people as possible. Another relative told us their family member had lost their dentures. These had not been found and no action had taken place to obtain replacements. This meant the person may have found eating their meals more difficult. We concluded the provider did not ensure the care people received was appropriate. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received a mixed response when we talked to people about activities. Comments included, "We went to the pub for a meal. It was such fun. We are going again at Christmas", "I love the singers and entertainers that come in", "I don't like bingo and they play it so often", "I am not keen on the activities; they do no suit me", "I would love it if they could arrange for a dancing group to come in", "They need to ask us individually what sort of hobbies and activities we would like to do" and "Nobody asks us if we want to do anything that's different ". Relatives raised concerns about the lack of social stimulation. One relative said, "When I visit people just seem to be sitting around doing nothing and sometimes the music that is on in the background is not suitable for most people. It's more suitable for the younger staff." People told us they were looking forward to Christmas activities which included a Christmas party and a children's choir visiting from a local school.

During the inspection we observed staff sitting with people and chatting. A member of staff painted some people's nails. However, we also saw some people sat for periods with very little stimulation.

The registered manager told us they had identified the level of social activity for people needed to improve. They said the activity worker post had been vacant from June to September 2017. In September 2017 a new activity worker had started but was no longer in post. The registered manager said they offered daily activities but acknowledged it was limited. A member of staff said, "We miss having a proper activities co-ordinator. We don't always have the time."

People we spoke with said they would feel comfortable raising concerns with either staff or the registered manager. One person said, "I would talk to anyone if I had a problem." Another person said, "I always say it like it is. I would say if I wasn't happy." A visiting relative said, "I have complained and everything was sorted immediately."

In the PIR the provider told us, "We have a culture of being open and honest, the management and staff are always happy to talk if anyone has a question or concern, any complaints that are received are actioned

immediately and relevant people kept informed." We saw information was displayed around raising concerns. One notice stated. 'Complaint is not negative. People should never feel frightened to speak up'.

The registered manager told us they had received four formal complaints in the last six months. Two related to the way invoices had been received. One related to health issues including the person not having their glasses, and a lack of communication with the family. The other complaint related to care and failure to contact a health professional in a timely manner. We saw complaints were investigated and where possible resolved to the satisfaction of the person.

We saw the service had received compliments. A visitor had stated in relation to care staff supporting people who use the service, 'It's a joy to watch'. Comments in surveys from May 2017 included, 'A big thank you to the staff. I think they do a fantastic job', 'Always made to feel welcome' and 'Couldn't be happier with the care'.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager. They were registered as the manager of Parkside Care Home in January 2017. We received positive feedback about the registered manager from people who used the service although some were unsure who they were. Comments included, "The manager is very nice but I don't see much of her", "The manager is smashing. She is so friendly", "I don't know the name of the manager but I always see the senior staff if I have a problem." A relative said, "The manager is great; nothing is too much trouble." Another relative said, "I tend to not see the manager about but there is always someone to help you if you need it."

The registered manager was knowledgeable about most areas that related to the management of the service, for example, they had a clear understanding of the staffing arrangements, the provider's auditing process and an overview of authorised Deprivation of Liberty Safeguards. However, they were unsure about some areas that related to the premises. They did not know the code to access the first floor, and when upstairs they were unsure where a staircase led even though this went straight onto the enclosed garden/patio area. Some monthly checks made reference to 'zones' but the registered manager was unable to explain which areas were covered by the different zones. The registered manager told us they had maintained a supervision matrix for 2017 but this was no longer available because they said they had 'thrown it in the bin'.

We saw the provider carried out regular checks and audits and these covered a range of areas. However, it was evident from the inspection findings their systems and processes were not effective because we found the provider was breaching four regulations. The provider had identified some of the issues we had picked up during the inspection, however, they had not taken appropriate action. For example, the lift floor was noted as a problem in July 2017. Emergency lighting was noted as an issue in March 2017. We also found they had not identified some issues, for example, the lack of bath/showering and limited menu options.

The provider maintained an auditing matrix which showed several audits had been carried out every month between April and November 2017. For example, in August 2017 ten audits were completed and the lowest score awarded was 88%; in November 2017 ten audits were carried out and the lowest score was 81%. They scored 100% for audits covering dignity, meals and nutrition, medication, pressure care, staff file and kitchen. They scored 97% for the daily chart audit. We saw a care plan audit was carried out six out of seven months between May 2017 and November 2017. The score had started at 90% in May and remained at 90% in November. A dip to 75% was noted in July. This evidences the care plan audits did not bring about improvement. The provider had identified the audits were not a good use of the registered manager's time and had decided from December 2017 a more focused approach would be adopted. We saw a letter which stated they wanted management to focus on driving improvement and would be reviewing this over January/February 2018.

In April 2017 the provider told us they had learned lessons following a safeguarding investigation which included improving their documentation and record keeping. At this inspection we found care records were inconsistent and did not always evidence whether appropriate care had been delivered. This meant

appropriate lessons had not been learnt because similar issues were found.

Staff told us they had opportunity to provide feedback about the service. They said team meetings were held regularly and they discussed things that were relevant to the service. We reviewed team meeting minutes from August, September and November 2017; topics of discussion included training, mealtimes, health and safety, improving documentation. In November 2017 it was recorded that there were issues with personal hygiene and people were not getting showered. Staff were told everyone should support people with activities. We found the issue relating to personal hygiene had not been addressed.

We saw staff were told at the November 2017 meeting that 'CQC would be coming in soon so please ensure you are filling in documentation accurately. At mealtimes everyone needs to be on the floor helping, you need to make sure that residents are not waiting for their meals. Also the dining room needs to be closed and disturbances need to be kept to a minimum.' We discussed these comments with the registered manager and a representative of the provider. They acknowledged these practices should be provided as standard because they improve people's experience, and should not only be provided because CQC are visiting.

People who used the service and relatives told us opportunities to share their views about the service were limited. Those who said they had shared views were not sure if their ideas were acted upon. We saw resident and relative meetings had been held, however, there was no record to show suggestions were followed up and meeting minutes did not have action plans. At a meeting in May 2017 people said they would like a sensory room in the small lounge but there was no information to show this had been considered. In September 2017 people were told a newsletter was being devised, however this was not available. In July 2017 people were asked to put forward ideas for future trips and said they would like to go to Scarborough, Filey and Bridlington. We asked if the trips had been provided but were told the ideas were for 2018; there was nothing to indicate people had been told they were putting forward ideas a year in advance.

The provider shared with us results from a survey carried out in October 2017. People who used the service, relatives, staff and health professionals had been involved. Five professionals had completed questionnaires; one stated the service was excellent and four stated it was good. All said the atmosphere was homely and welcoming, and staff were friendly and supportive. One stated they were unsure if they were satisfied with the standard of care the person they visited received. Seven relatives had completed questionnaires; all stated people were treated with respect and received care that met their needs. Three stated people could make decisions about their care; two stated they did not know and two stated people were unable to make decisions. Four stated people could join in activities of their choosing; one stated they did not know and two stated they did not agree. Five staff completed questionnaires; they all said they felt supported and enjoyed working at Parkside.

Nine people who used the service completed questionnaires; responses relating to friendliness of staff and people like their bedrooms were positive and agreed by all. Responses relating to activities, help to get a bath or wash, meals and choosing what to wear were not agreed by all. There was no evidence of any follow up and the action plan stated, 'To continue to support and encourage residents to talk about the things they like to do'. This does not evidence people's views were used to drive improvement. We concluded the provider did not operate effectively systems and processes. The systems and processes did not enable the registered person to assess, monitor and improve the service or assess, monitor and mitigate risk. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found the provider's systems and processes were not effective, we saw some quality

management systems were effective. For example, a quality performance indicator monthly report was completed and covered areas such as safeguarding alerts, serious untoward incidents, external inspections, complaints and training. We saw the report from October 2017 showed aspects of the service was being monitored. For example, it was noted two people who had lost weight were gaining weight. A safeguarding case had been closed and a complaint had been responded to following the outcome of the safeguarding. An accident and incident analysis showed the provider had a system for identifying trends or patterns.

The provider had an independent inspection carried out on 9 and 10 November 2017. The report was shared with the provider on 7 December 2017, the day before our inspection. This identified areas of good practice and areas of concern. Areas of good practice included, staffing was well organised and recruitment was generally effective, and staff knowledge of people who used the service was excellent. Areas of concern included, care files were not routinely audited or cross referenced to each other, and there was a lack of leisure and social activities. The registered manager said they would be working through the report and developing an action plan based on the findings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure the care people received was appropriate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not assess and manage risk to people who used the service. The provider did not ensure the premises and equipment were safe to use. The provider did not assess the risk of and take action to control the spread of infection.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure people's nutritional needs were met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not operate effectively systems and processes, and the systems and processes did not enable the provider to assess, monitor and improve the service or assess, monitor and mitigate risk.