

Bupa Care Homes (CFChomes) Limited

Parkside Care Home

Inspection report

Parkside Road
Reading
Berkshire
RG30 2DP

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20 November 2018

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Ratings

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

Summary of findings

Overall summary

Parkside is residential care home for up to 72 people, that provides a service to both older and younger adults, and people who may have physical disabilities. The service is registered to provide accommodation in addition to personal and nursing care to people. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The home offers 72 en-suite bedrooms and multiple communal rooms, kitchenettes, dining rooms and additional bathrooms across three floors. A spacious rear garden further offers additional space for people to use. All floors are accessible by an operating lift and stairs.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Why the service is rated good

The service continues to keep people safe. Recruitment procedures and staff deployment ensured that sufficient staff are employed to support people and help keep them safe. Risk assessments continued to consider least restrictive options to enable people to continue engaging in activities that they appreciate and brings them joy.

Medicine management continued to be provided in a safe way, with audits illustrating that people received their medicines in a timely way and how they wished. Medicines were stored correctly, and ordered to ensure that people were not without their medicines at any point.

Staff training was kept up to date, and a plan was being actioned to ensure appropriate supervisions and appraisals took place that allowed reflective practice.

People's needs were assessed initially upon admission, and thereafter reviewed monthly to ensure care was the most appropriate. People were encouraged to personalise their rooms in a style that they preferred, with furnishings that brought a personal touch to their rooms.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. This included making decisions about their care, food choice as well as activities. The policies and systems in the service supported this practice.

Staff approach remained caring. People were supported by a staff team that knew them well, and ensured they enabled them to maintain their independence, and retain things important to them. Where care

support was required, people's dignity and privacy was maintained. People communicated in their preferred way, with records clearly highlighting this.

The service continued to focus on the delivery of person centred care. Care plans were written for people, detailing how they wished to be supported. Activities, both in-house and external were responsive to peoples preferences. With specific activities created for people to enhance their well-being.

The service continued to be well-led. There was a clear vision and direction from the senior management team that reflected on staff practice. A new manager had been appointed who was in their induction process. Whilst new to the service, they hoped they could bring their expertise forward to ensure the service continued to progress in the right direction. An open door policy was practiced, whereby staff were able to approach the management team and discuss any issues.

Good community links were created, and the service worked efficiently with visiting health professionals. The service continued to have good governance and reflective practice, ensuring compliance with the regulations.

Further information is in the detailed findings within the 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? The service remains good.	Good ●
Is the service effective? The service remains good.	Good ●
Is the service caring? The service remains good.	Good ●
Is the service responsive? The service remains good.	Good ●
Is the service well-led? The service remains good.	Good ●

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.

This inspection took place on 19 and 20 November 2018 and was unannounced. The inspection was completed by two inspectors.

During the inspection process the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service, this is a legal requirement. As part of the inspection process we also look at the 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. We had received the PIR for Parkside and used this to help inform our inspection plan. During the inspection we spoke with 10 members of staff, including, two RGNs, one activities co-ordinator, two care workers and four of the staff from the senior management team. We spoke with 10 people who are supported at the service, in addition to two relatives.

Care plans, health records, additional documentation relevant to support mechanisms were seen for eight people. In addition, a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. Staff recruitment and supervision records for eight of the newly appointed staff were looked at. As part of the inspection process we completed observations during lunchtime, as well as interacting with people over the inspection process. We reviewed 15 medicine records across all three floors.

Is the service safe?

Our findings

The service continued to provide safe care and treatment to people. People told us, "I feel very safe here," and "I know I am in safe hands", when we spoke with them regarding the service. Staff remained knowledgeable in safeguarding. They were able to identify the different signs of abuse and further advise what action they would take should they suspect abuse. All staff spoken with during the inspection said they would not hesitate to whistle-blow. They were able to identify the provider's whistle-blowing policy, as well as consider external agencies who could be notified if abuse was suspected. One staff we spoke with said, "I wouldn't hesitate, why would I? We're here for them, to make sure they are okay."

Risk assessments were completed on potential risks to people, and reviewed on a monthly basis, or sooner if the risk occurred. These assessments focused on enabling people to maintain an active, independent life as possible, whilst ensuring they remained safe. For example, where people were at risk of falls, measures were implemented that enabled people to move freely within the service, with actions on how to mitigate the risk. This could be focusing on footwear, ensuring all obstructions were removed or introducing the use of mobility aids. Other examples included people being able to eat the foods they liked, going on external excursions and risk assessments based on people's physical needs. By ensuring risks were assessed people were given the confidence to complete some tasks independently. One person said, "I am able to move around, and go to the bathroom independently. That was very important to me."

The service continued to ensure sufficiently suitably checked staff were employed to support people. A robust recruitment process was in place that ensured that staff recruited met schedule three of the Health and Social Care Act. Where there were vacancies, this did not affect the staffing ratio. A number of bank workers were used where necessary, with staff assisting and completing additional shifts. If a shortfall remained, consistent agency staff were used to ensure they knew people well. However, records indicated infrequent agency use.

We observed staff administering medicines, and noted their practice was in line with best practice guidelines. A qualified nurse administered medicines per floor. We observed that people were supported to take their medicines how they wished. For example, with juice or water. Medicines were stored safely and ordered correctly. Medicine audits took place frequently, and illustrated that medicines were managed safely. "As required" medicines had comprehensive details of when these needed to be given and why. Records showed these were only given when the guidelines were met. Where people were non-verbal information on body language and facial expressions was provided.

The service was clean. The domestic staff were observed on each floor cleaning all areas. Relevant measures to prevent and control the spread of infection were taken. Colour coded cleaning products were used to prevent the spread of germs and possible infection from one room to another. The service had recently been inspected by the Food Standard Agency (FSA). The FSA is responsible for food safety and hygiene across the UK. Provisions are measured against a set of standards and scored in accordance to these. Parkside was rated 5 out of 5, the maximum score obtainable.

Trends analysis continued to be completed for all accidents and incidents. This ensured that the service learnt from reportable issues, and then took the necessary action to prevent similar occurrences, where possible.

People were protected and kept safe regardless of their ethnicity, religion, sexuality, gender or disability. The service had a strong drive of inclusivity and ensured that all people and staff felt safe, in line with the company's equality diversity and human rights policy. We observed staff being treated in line with this legislation, who in turn ensured that this was put into practice.

Is the service effective?

Our findings

People continued to receive effective support that ensured their rights were maintained in line with the Mental Capacity Act (MCA). People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS). The service had ensured where necessary all applications were made to the local authority. Where necessary best interest decisions were made for people. These where applicable were made with relatives or health professionals' involvement; and only when a person was unable to make an informed decision for themselves. Where a relative held lasting power of attorney (PoA), documented evidence was retained in people's files to illustrate that they were able to make decisions on behalf of the person. The lasting PoA can be for health and welfare or finance and property. In some circumstances relatives hold both.

People's needs were continually assessed with care documentation being updated as and when required. The regional director advised that he was hoping to implement more person-centred documentation. Staff completed in-house training that met the requirements of the care certificate as part of their induction. They further completed shadow shifts with more experienced staff prior to working independently. The service had a rolling training programme in place, that ensured staff received refresher training as and when required. Any additional training to further support people was sourced as required. Staff reported feeling confident that they were provided with sufficient knowledge to effectively carry out their duties. Whilst supervisions were carried out frequently, appraisals were completed ad hoc. The new manager had developed an annual plan for all supervisions and appraisals to ensure that these could be caught up on.

People continued to be encouraged to eat and drink healthily. The service had a monthly menu, that was rotated. Several meal options were made available with additional food prepared where people did not want to eat food from the menu. Where required, support was sought from external professionals such as speech and language therapists or the dietitian, to help develop plans around nutrition and hydration. For example, where a person was at risk of choking, rather than automatically considering a thickened diet, the service chose to work with the health professionals and the person to enable them to eat all foods; whilst working on changing their eating habits. Staff sat with people and encouraged them to eat slower. Where this was found to be ineffective a soft food diet was introduced, and monitored. People told us, "The food is very good." "I cannot complain about the food, apart from there is too much at times!" One relative reported, "They ensure [name] has their needs met when it comes to eating. All the staff, including the chef are aware of what can / cannot be eaten. I don't know how they remember." The chef held this information on a need to know basis, which was not accessible to all. This not only ensured the person ate the appropriate food to manage their nutritional needs, but worked in line with General Data Protection Regulation, therefore ensuring personal information remained confidential.

The service continued to maintain comprehensive records of all input people received from health professionals. This included visits to / from the GP, dentist and any additional professional involved in the person's care. Relatives advised that the service responded well to people's changing health needs. Support was sought within a timely fashion and medical advice followed through by the staff. One person said, "They

will always call the doctor when I request for an appointment. They are very good."

People were encouraged to personalise their rooms, in a way that was reflective of their personal preference. We saw each bedroom was decorated how the person wanted, with personal photos or artwork that held personal value to them adorning walls. Each bedroom was en-suite with a wet room, enabling people to remain independent where possible, and also have the accessibility of their own bathroom where personal care was needed.

Is the service caring?

Our findings

The service continued to offer a caring service to people. They were supported by a staff team that knew them well and focused on developing a positive relationship with them. We observed staff speaking to people both kindly and compassionately. People told us, "The girls are very good, they care a lot." "[deputy manager] is wonderful, she really does care." Touch was used where applicable, with discreet words to redirect a person if required. Staff were trained in understanding dementia care, and the need to allow a person to have an opportunity to process information. Training was specifically designed at understanding each person, and how the service could best meet their needs.

Where people required support with personal care, this was offered to the person at a time that they requested or when needed. Staff would redirect the person to their room if they were out, ensuring the door was closed to maintain the person's dignity at all times. The service used a sign on the door, that advised personal care was being delivered, therefore not to enter. Where applicable curtains were drawn, and people were covered as required. Staff tried to encourage people to remain as independent as possible with all aspects of their care, including personal care and eating. For example, we observed several people over lunch who had varying abilities that could potentially restrict their ability to eat independently. Rather than de-skilling the person, the service used utensils and crockery that would enable the person to independently eat. Advice was sought from the occupational therapist and physiotherapist, to determine what items to use. In addition, staff used motivational strategies over lunch, gently encouraging people to persevere with their food. This allowed people to maintain their dignity and independence in this area of their life. Where it was noted people continued to struggle, staff would offer assistance, this might be to simply cut the food up into mouth size portions or to fully assist with eating.

Similarly where a person's preference was to eat alone, and not in the company of others, staff ensured the person's choice was respected. People were offered the opportunity to eat in the communal dining room, if they declined the meal was offered in the communal lounge or bedroom. We observed staff assisting people with their food. Whilst the experience was generally positive for people, we noted that staff were often focusing on several tasks. For example, assisting one person with eating, filling another person's glass with a drink and prompting a third person to eat more. We spoke with the management team regarding the experience specifically noted on the second floor. Staff deployment or staggered lunch were ways the management thought this experience could be further enhanced for people, allowing the person being supported to have the undivided attention.

Monthly key worker sessions focused on the person, and enabled them to be actively involved in making decisions about their care. In addition, people's meetings were held at Parkside that focused on day to day issues as well as operational issues. Minutes of these were maintained.

Each person's file contained a communication passport. This looked at the person's preference of communicating, and provided key phrases, pictures, expressions and words with meaning, for any new staff. This was considered a working document, that evolved with the person, as they used new communication methods and became more confident in expressing themselves.

The service continued to maintain people's confidentiality. Records were kept in secured facilities within the offices per floor. If staff required speaking about a person, they ensured they removed themselves to a quiet place where their conversation could not be overheard.

Is the service responsive?

Our findings

The service continued to respond to people's changing needs. Care plans retained information and insight into how people wished to be supported and cared for. This was documented appropriately and written in simple language, ensuring all staff understood the support process. Information obtained from initial assessments, visits prior to moving to the service, family and professionals was used to inform each section of the care plans. These were written generally in the first person focusing on person centred care. Where people were unable to provide information the care plan, this was written in the third person.

People were encouraged to be involved in their evolving care plans. Each person had a key nurse and a key care worker assigned to them. They were encouraged to discuss their care needs on a monthly basis, if possible. The purpose of this was to emphasise and empower people to lead their care. All care plans were further reviewed monthly as part of the "resident of the day" approach. This audit process focused on ensuring all care plans, health information and risk assessments were up to date for people. People told us, "Yes, I was totally involved." And, "I receive the care the way I wish to receive."

An example of how the service promoted person centred care, was where people did not consent to assistance and this was not offered. Staff would suggest alternatives, including coming back at a later time, or an alternative member of staff offering support. The person was always given the opportunity to drive the level of support they wanted and when they wanted it, where possible.

The service had a complaints procedure in place. We saw that issues were responded to appropriately and within the company's stipulated time frame. A written record was maintained of all concerns and the feedback provided to the complainant. Where possible, the service used this as a learning tool to prevent any similar occurrences. One recent example that was discussed with the management team, was the new manager seeking to make physical changes to the communal lounge and dining room. Furnishings were changed to encourage more congregation between people. However, several people were unhappy that changes had been made to their space without consultation. They raised formal complaints, which were correctly documented. The manager acknowledged the need for consultation and reverted all furnishings to their original space. The manager advised that they had learnt from this, and would ensure that a consultation process was implemented where possible in the future.

People remained engaged with activities, both within and outside the home. We saw that activity timetables, were responsive to people's preferences. Some people enjoyed attending activities in small groups, whilst others preferred activities on a one to one basis. The staff worked hard to ensure people achieved inclusivity within the community. The service was in the process of creating links with a local pre-school for children to visit Parkside and spend time with people. We were provided with an example of how the service wished to respond to people's specific needs. The service was approached by a relative regarding an anniversary that they wished to celebrate, with a person who was residing at the home. The service responded, by creating an intimate dining experience. A table was set up in the person's room, with a gift purchased by the service. Petals were thrown on the table and an intimate meal was prepared by the chef. The experience was not only positive for the person, but also the relative. They sent a thank you card to

the service, expressing their gratitude at how positive the experience had been for both.

The Accessible Information Standard (2016) was incorporated into the service. This legislation focuses on people receiving information in a way that they understand. The service ensured that information was presented in a format that people could use, including writing boards, symbols, bold text, or simply documenting when information was discussed with the person. Where required, issues were discussed with the person who retained the power of attorney for health and welfare.

At the time of the inspection no one was receiving end of life (EOL) care. The service did nevertheless support people during this process. We were provided with information on the course that is followed when a person is determined to be EOL. This included seeking medical input and advice, nurse management of care, review of nutrition and hydration, person's and family wishes and ensuring the person's final moments were as dignified as possible. Feedback seen from relatives, where people had received EOL care from the service was positive and supportive of the methodology implemented.

Is the service well-led?

Our findings

The service continued to be well-led and managed by a consistent senior management team who had been in post for a number of years. The manager was newly appointed having been on induction for four weeks and based at the service for only three weeks at the time of the inspection. The process of registration with the Commission had commenced. 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 service had a clear vision of inclusivity. The deputy manager further drove the belief that all people were equal irrespective of their race, disability and faith. This approach was inclusive of staff, who were enabled to wear items of religious significance, whilst at work. For example, a crucifix necklace or a hijab. The deputy manager and staff team focused on empowering people to achieve their personal goals. Whether this was to complete independent tasks like pouring themselves a drink, to independently completing personal care tasks.

The service continued to respond to feedback received from people, relatives, professionals and stake holders. Annual quality assurance audits were completed from which an action plan was created. This was used to inform the service as it continued to develop and progress, meeting people's changing needs. A visual board was on display that read, "you said, we listened". Examples of feedback that had been given was provided on the board, with how the service had actioned this. Relatives acknowledged that issues were responded to within a timely fashion. Similarly, on day one of the inspection we found that call bells were not located in all communal bathrooms. We discussed this with the management team, who advised that these had been removed as all rooms were en-suite. We queried how people or visitors were kept safe, if they used any toilets in communal areas, specifically if call bells were removed. By day two we saw that call bells had been reinstalled in all communal bathrooms. The management team acknowledged that this was an oversight, and rectified this immediately.

Monthly team meetings, monthly house meetings, clinical meetings and complaints were also used as part of the quality assurance process. Where changes to the service or practice were required these were planned and implemented as required. The process was seen as one to ensure person centred care was experienced by people residing at Parkside. Whilst operationally seeking to use the process as one of continual learning and improvement.

The service continued to audit the service using monthly, weekly and quarterly schedules. Care documents, house safety checks, staff training and support checks, as well as medicine audits all showed compliance. The audits completed by the regional director highlighted where there was need for further development. An action plan often accompanied the regional director's audits. The in-house management team ensured that all items were corrected, signing off when the task had been completed. Audits were in line with the Health and Social Care Act regulations and worked on a traffic light system, indicating level of compliance at quick glance. The service appropriately notified the CQC of any notifiable incidents.

The service continued to work in partnership with external agencies. Advice was sought within a timely fashion from health care professionals and stake holders. The deputy manager and staff strove to work with external agencies to ensure people were able to achieve their aspirations, and receive the best care that could be delivered. The manager, although new, hoped to continue the process of creating a compliant and open culture, whilst acknowledging the need to build a relationship with relatives, people and staff alike.