Shivshakti Nivas Ltd.

Park House Rest Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 11 December 2015. Park House Rest Home is a care home, which accommodates up to eighteen older people, some living with dementia. On the day of our inspection 17 people were at the home. During the inspection one person left the home as they had only been there for a respite visit.

The service does not have 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 was registered on 26 June 2015 and a condition of their registration was they needed to have a registered manager in post. The service had a manager, who in this report will be referred to as the manager. They have not applied to the Commission to become registered.

Risk assessments had not been consistently competed in all relevant areas of care planning and had not always

Summary of findings

been updated as people's needs changed. Staffing levels were not planned and there was not enough staff on duty to meet people's needs. Recruitment checks on staff were not adequate to ensure the safety of people. Staff had an awareness of how to keep people safe and what action they should take if they had any concerns. Medicines were not administered, stored and recorded safely.

Staff had not received adequate training to ensure they could meet people's needs. Staff were not receiving formalised support in the form of supervision sessions. Some staff had a basic knowledge of the Mental Capacity Act but people's capacity to make specific decisions had not been assessed. People enjoyed their meals but records of people's nutritional intake were not adequate to know a person's food and fluid intake. People were supported to access a range of health professionals.

People did not always have their individual needs met in a personalised way. People felt confident they could make a complaint and it would be responded to, however no records were made of complaints.

The home did not have good leadership and the registration requirements have not been met. There are not effective procedures in place to ensure a good and safe quality service is provided.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found breaches in seven of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We are taking further action in relation to this provider and will report on this when it is completed.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Some people's risk assessments were not reflective of their current risks and did not guide staff on how to care for people.

Staffing levels were not planned to ensure the needs of people could be met.

Recruitment procedures were not adequate to ensure the safety of people.

Staff had an understanding of how to safeguard people and what action to take if they thought people were not safe.

Medicines procedures were not safe.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received training to ensure they could meet people's needs safely.

Staff had a basic knowledge of the Mental Capacity Act 2005. This did not ensure consent was obtained legally.

People did not always receive appropriate support and records of people's nutritional intake were not adequate.

People were supported to access a range of healthcare professionals.

Is the service caring?

Requires improvement

The service was not always caring.

People were supported by caring staff.

People were given privacy but not always treated in a respectful manner.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive personalised care, which was in line with their needs or preferences.

People felt they could complain but records were not maintained of these.

Is the service well-led?

Inadequate

The service was not well led.

There was no overall leadership for the home.

Summary of findings

There was no registered manager and no application to register a manager had been made.

Records of care and the management of the service were inadequate

There were no effective systems in place to ensure people were receiving safe and good quality care.

Park House Rest 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 comprehensive inspection took place on 11 December 2015 and was unannounced, which meant the staff and provider did not know we would be visiting. The inspection team consisted of one inspector, a specialist advisor in the care of frail older people, especially people living with dementia and those with end of life care needs, 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 care service. The expert had experience of caring for people who have dementia. We visited the service between the hours of 10:30 am and 6:30 pm.

Before the inspection, we reviewed notifications. A notification is information about important events which the provider is required to tell us about by law. We also looked at any information we had received since the provider had been registered with us.

During the inspection we spent time talking to twelve people, four staff and two visitors. We looked at the recruitment records of four members of staff. We were given copies of the duty rota and of two internal audits.

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 observed interactions between people and staff.

Inadequate

Is the service safe?

Our findings

People felt safe and told staff if they had any concerns. They were confident staff would act on their concerns. Staff had a mixed knowledge of safeguarding procedures and policies. Some staff could report what safeguarding meant and what they would do if they had concerns. Other staff were not as sure and were unable to tell us what the term 'safeguarding' meant. However all staff did report if they had any concerns over people's safety they would report them to the manager who they had confidence would act on their concerns. No safeguarding referrals had been made and during the inspection we did not see the need for any referrals to be made.

People had risk assessments in their care folders, which related to the sections of their care plans. However these had not always been completed where necessary and were not always reflective of people's current risks. For example we saw one person with bruising on both wrists. The person could not tell us how this had happened but told us they had very thin skin and that they were on a particular medication which made them bruise easily. However there was no risk assessment or information relating to this in their care records. Their care plan made reference to agitation, low mood and mood swings. No risk assessments were in place to guide staff on the possible risks these could have on this person. Records showed three people had lost weight in the past few months. No risk assessments were in place to guide staff on how to support people to prevent further weight loss.

The lack of effective risk assessments in place to ensure the safety and welfare of people was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff were aware of the whistleblowing policy, whereas one member of staff was unsure what this referred to. However they were confident if they had concerns the manager would be responsive to the information. The home had a recent fire inspection by the fire officer and we were advised by the manager there had been some requirements made, but they were awaiting the report. They were unable to locate their own fire risk assessment.

No tool was used to assess how staffing levels were sufficient to meet the needs of people. We were told the usual staff pattern was to have two members of care staff on duty covering the hours of 8:00am and 9:00pm with a cook working seven days and a member of domestic staff working most days of the week. Nights were covered by one sleep-in and one waking member of staff. The manager worked in the home most days but their hours were not recorded on the duty rota. Care staff told us when the home was full the staffing levels usually rise to three staff during the core hours. Staff talked of meeting people's needs in a task orientated way. One staff member said, "It is easier with three staff. We ask ourselves at the start of the shift what we have to do and then we get on with it".

We looked at the duty rotas for the week beginning 30 November 2015 - 27 December 2015. These recorded a sporadic pattern making it difficult to establish how staffing levels were planned to meet people's needs. On some days there were identified gaps where it had highlighted agency staff were needed. There was no evidence these gaps had been covered. On other days there were gaps on the duty rota where no staff were identified as working but these had not been highlighted as needing to be covered. There were times during the inspection when we needed to alert staff that people needed assistance. Staff did not always respond to people who were requesting assistance because they were busy supporting other people.

For example, we went into a person's room who was calling for assistance and noted a strong faecal malodour. The person identified to us their legs were uncomfortable. We asked staff to support the person and they responded kindly. However after leaving the person was again calling out and we noticed the position of the person had changed but the aroma remained. We spoke with the same care staff who told us "Oh it must have been a bit of wind". We asked them to check again, which they did and this time they changed the person's absorbent product which was wet and contained faecal matter. On another occasion we heard a person in their room choking. We alerted staff who again offered support promptly and in a cheerful manner. When asked, the staff reported the person had been sick. Staff offered support in both circumstances in a caring manner but we were concerned these people may have got the timely support had we not alerted staff to these situations.

People's needs were not always met by sufficient and consistent numbers of staff. This was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service safe?

Staff recruitment records demonstrated appropriate checks were not always undertaken before they worked in the home. For one staff member there was no photographic evidence and no date when they had started work. For another staff member there was only one written reference which was from a personal friend and it was noticed under 'company stamp' they had drawn a smiley face. For the third member of staff there was no photographic evidence, no evidence of checking with the DBS (The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions) and no start date. For the fourth member of staff there was no photographic evidence, no check with the DBS and no start date was available. The manager told us they thought the missing information was available but they could not find it during the inspection. We advised if they found it within 48 hours we could consider it as evidence. No information was sent to us.

The lack of effective recruitment procedures did not ensure people's safety. This was a breach of Regulation 19 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

The storage, administration and recordings of medicines were not safe. The controlled medicines cupboard was being used to store general items as well as appropriate medicines. A fridge in the communal area storing medicines was unlocked, which meant people had access to the medicines stored in the fridge. The day to day medicines trolley was full and disorganised. Four plastic medicines pots which contained unidentified medicines fell out when we tried to close the trolley. As they were not labelled it was not possible to know what these medicines were.

Five people had blank covers in front of their Medicines Administration Records (MAR's). Their names had been written on the bottom of the blank sheet, there was no photograph of the person and no dates of birth or allergies had been recorded. This made it difficult to identify the person and increased the risk of error. People's MAR charts showed there were some missing signatures where staff ought to have signed to confirm administration. We spoke to the manager about this who told us, "I am sure people had these but the staff were probably busy and just forgot to sign for them." For four people prescribed 'as and when necessary' (prn) medicines the MARs did not contain a prn care plan or protocol. These care plans an important part of ensuring people receive the medication they have been prescribed as and when they need it through written guidance.

We observed the manager administer medicines to people in a way which demonstrated they did not have the skills and sufficient knowledge to do this safely. They used the same medicines pot five times with different people. They wore the same gloves as they undertook the medicines round and they gave three people their medicines from blister packs into their gloved hand and from there to the hands of two people, without drinks. For the third person they put the medicine straight into the person's mouth. The person had difficulty in swallowing the medicine and they did not have a drink. The manager then put a pot to the person's mouth, which contained liquid medication; this had not been dispensed effectively by the manager as it had not been measured accurately. The person refused to take the medication which has a strong aroma and an unpleasant taste. They were not offered a drink with this medicine. We observed the person did not receive the lunchtime dose of their medicine.

No regular medicines audits were conducted at the home by the provider. An annual audit was completed by the Pharmacy who provided medicines to the home. The manager stated there was a check of medicines when they were received from the pharmacy each month by two members of staff. During the inspection the manager could not locate a record of this.

The lack of safe medicines administration practices was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People enjoyed their meals and told us they could have their meal in the dining room, lounge or in their own room.

The manager could not access staff training information. We were unsure as to the reasons why as we were told this was on the computer. The manager advised they would be able to send us this information following the inspection; we agreed a date when this would be sent to us. The information was not sent by this date and has not been received. Two members of staff told us they had undertaken training during their four day induction, which had been given by the manager. They advised since their induction they could not remember completing any training.

The manager told us they had not had time to arrange supervision sessions with people. They had started to plan these, but did not have a formal plan to show us. When we spoke with staff they told us they felt supported in their role but had not had any formal supervision sessions.

Staff were not receiving appropriate support or training. This was a breach of Regulation 18 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Consideration to the Mental Capacity Act (2005) had not always been evidenced in people's records. 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.

Whilst we found some staff, but not all, had some basic knowledge of the Mental Capacity Act consideration of the Act had not always been given. For example, one person had bed rails in place to ensure their safety when in bed. However there was no information to show this person had consented to the use of this equipment. No assessment had been completed to see if this person had the capacity to agree to the use of this equipment and no best interest decision had been recorded if they had been assessed as lacking capacity to make the decision themselves. Another person was wearing hip protectors. Their care plan detailed no assessment of the person's capacity to agree to these and no best interest decision was recorded.

DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) forms were in people's care plans. Some of these had been signed by relatives. There was no documentation which showed the signatories had the legal right to complete these forms on behalf of the person, or that the person lacked the capacity to make these decisions.

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 Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Applications to deprive people of their liberty had been made to the local authority responsible for making these decisions. However the manager had limited knowledge and thought these only related to people's freedom to leave the home.

The lack of assessing people's capacity and ensuring their consent was a breach of Regulation 11 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

Records in people's care plans were basic and did not detail their nutritional needs. When people lost weight this was not transferred to their care plan. Two people were on a food and fluid chart. For one of these people, where there was concern about their nutritional intake, no weight chart could be found. This person was also prone to urinary tract infections; fluid charts which were in place to monitor their fluid intake and output were poorly managed and lacked details to inform the care they needed to reduce the risk of urinary infections. Information was completed for only three days in November 2015. On one day 200ml of fluid intake had been recorded and the other two days showed an intake of 650ml. This was not an adequate fluid intake. Food and fluid charts for a second person were also poorly maintained. There was no fluid intake target and daily totals had not been added up. From these it was not possible to establish what the person had eaten or drank on a daily basis.

Inadequate

Is the service effective?

Records held in the kitchen relating to people's nutritional needs had not been kept updated and were not an accurate reflection of people's current needs. For example some of the information related to people which was dated in the year 2012. People who needed support at meal times were not always supported in a respectful manner at meal times. During the evening meal there was friction between two people at the dining table, which resulted in them shouting at each other. A member of staff, who had been supporting a person to eat their meal in the lounge, left the person and stood over the dining table. They asked one person to "Stop laughing" and continued to stand over the table for ten minutes, which left the person they had been supporting without any support to eat their meal. People, who were more independent and stayed in their rooms, told us they enjoyed their meals.

The lack of clear records regarding people's nutritional needs and intake was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.

People had been referred to health professionals as necessary. Details of the referrals and appointments were maintained in people's records. People had been referred appropriately to health professionals; however advice provided by health professionals was not always recorded into people's care plans. For example specific advice about a person's diet had not been put into their nutritional care plan.

Requires improvement

Is the service caring?

Our findings

People were positive about the nature of the staff. “I can’t speak highly enough of the staff, they are all lovely”, was a comment from one person. Another person told us, “They’re very good; kind and helpful.”

Staff were caring towards people they were supporting. They treated people with kindness and were patient with people. Staff demonstrated they knew people as individuals and had knowledge of how to support them as an individual. Staff were patient when talking to people and would make sure the person understood what they meant when explaining something to them. We were concerned a member of the staff team did not always speak to people in a respectful manner. This was more a lack of understanding of how to work with people who have memory impairment rather than a lack of a caring nature.

It was possible to establish from some people that they were involved in some decisions regarding their care. However other people were unable to tell us this direct information. Where reviews of peoples care plans had taken place, there was no evidence people had been included in these reviews. People who were able to express their views felt able to influence their care, but there was a feeling staff were too busy and people did not want to bother them. For example one person had enjoyed walking in the garden for exercise but now needed support to access the garden. They reported this was not planned into their routine but they had to ask staff, who were always busy. When we looked in one person’s records it was noted in their pre-admission assessment they preferred a bath in the evening. Records showed the person had received support with showers, none of which had been in the evening.

Staff mainly spoke with people while they were providing care and support in ways which were respectful. Staff ensured people’s privacy was protected by ensuring all aspects of personal care were provided in their own rooms. Doors were always kept closed when providing personal care to ensure people’s privacy and dignity was maintained. Relatives were welcome at any time and they said they were always made welcome. Two people received support on a daily basis from relatives who called to support them with their lunch time meal. The home only had one large communal lounge/diner, which made the issue of privacy more difficult especially for those sharing a room, if they wished to see visitors in private.

Inadequate

Is the service responsive?

Our findings

There was evidence people had assessments before and when they moved into the home. From the assessments care plans were developed. However care plans were not detailed and did not give staff adequate information to ensure people's needs could be met. Records did not reflect people were involved in the planning of their care and in the reviews of their care.

Care plans were brief and did not give sufficient detail to ensure staff knew how to care for people. There was contradictory information in care plans, where part of a care plan had been updated but another section had not, which made it unclear what the person's current support needs were. For example for one person the assessment, which was not dated or signed, stated the person had no special diet. However in different parts of their care plan there was conflicting information to this which stated the person had specific requirements. When looking at notes from professional visits there was a note to say the GP had advised to push fluids. However this information had not been added to a care plan and it was not possible to establish this advice had been followed. It was not possible to establish from the care plans what this person's current abilities and support needs were in relation to their nutritional needs. Food and fluid charts had been spasmodically maintained but when completed these did not give a clear picture of what the person had eaten or drank. There was a lack of clarity for this person regarding their skin integrity. A risk assessment had been completed in December 2015 which stated the person 'bruises easily due to skin integrity being frail'. However the skin integrity care plan dated May 2015 recorded 'Skin integrity is good'. The care plan had not been updated to reflect the change in the needs of the person. In the medical appointment notes there were three entries relating to one bruise and two skin flaps. However the care plans made no reference to these incidents.

In a second person's care plan it stated the reason for admission had been 'Agitation'; however there was no care plan relating to this behaviour. In the medical appointments section there was reference to the person having had low moods, but there was no care plan relating to this information. In a third persons care plan we looked for the reasons why the person was on "Bed Rest". We could find no reason for this in all sections of the care plan. A risk assessment for this person dated 12 October 2015 recorded they suffered reoccurring UTIs (urinary tract infections) which caused them to become increasingly more agitated. There was no care plan relating to this information and no fluid charts were available for this person.

There was a lack of detail in people's records as to what their wishes were regarding activities. There was a timetable of activities, but most revolved around the 'Crafts Person', who was employed by the home. There was very little engagement for people who were not mobile or had a higher degree of mental impairment. People did not take part in personalised activities. When we asked the manager about activities they told us they were aware there was a lack of individual activities for people and was hoping this would change in the future. We noted in one person's list of activities it recorded, 'Television/radio, music, gardening and reading'. We could not see there had been any record of these activities in the six weeks they had been in the home. When we visited the person in their room it was noted they had no access to music/radio and there were no books in their room.

The care and treatment of people was not always person centred and did not always meet people's needs in an appropriate way. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able, and their relatives, felt able to complain and had confidence their complaint would be listened to and acted upon. The manager advised us they did not keep a complaints log but that there had been no complaints. However we heard about two complaints being made, one form a person and another from a staff member. As no complaints had been logged we could not establish complaints would be dealt with in an effective manner or that there would be learning from complaints made.

The lack of an effective complaints procedure was a breach of Regulation16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The manager had a good relationship with staff in the home and often spent time working with them to meet people's day to day needs. Staff also had faith in the manager and believed if they reported any concerns to her they would be looked into. Staff were not aware of the values and vision of the home. The manager was also not aware of any values that had been written down. We asked to see a copy of the Statement of purpose which we saw recorded the aims and objectives of the home. However this Statement of purpose which was displayed in the home, belonged to the previous provider and had their details listed. We asked the manager about resident and staff meetings. We were told the home does not undertake residents meetings but there had been staff meetings. We asked to see the minutes of the staff meetings but the manager advised she had not typed these up yet and the notes were not available. We asked for the minutes to be forwarded but these were not received. We could not establish that there was any formal way of including and recording the involvement of people or staff in the development of the service.

The home was registered in June 2015 and a condition of the providers registration was the home was managed by a registered manager. The home is not managed by a registered manager and no application has been received by the Commission to register a manager. The manager advised that the nominated individual for the provider visits on a daily basis. The manager advised the nominated individual was supportive and they were involved in the financial running of the home.

The manager told us they had been overwhelmed by the amount of work they had undertaken when taking on the role of the manager. They were not well organised when it came to paperwork and had piles of papers, which we were told were awaiting filing. When we asked for evidence of audits, meetings, policies, training records, incident reports and complaints the manager was unable to locate these. On some occasions we were told they were in the piles of papers, or unable to be located on the computer or were in hand written notes which were not available. The manager was aware this was not adequate but also commented they had also spent time providing care to people, which had taken them away from their management role.

The manager gave us copies of the last two internal quality audits from September and October 2015. These were completed by the manager and the nominated individual of the provider. These were broken down into eight main areas and included space for needed improvements and an overall summary. However the quality and effectiveness of these audits was questionable as they did not identify the areas of concerns we found during our inspection. For example when looking at 'Care plans' the audit for October 15 recorded, "Doing them well and thorough". In 'Staffing' October 2015, the audit asked, 'Are there enough staff on duty, How many staff should be on duty – what is the staffing ratio? The audit had just recorded an answer, Y (indicating yes) and how many residents were in the home. Under 'Staff Supervisions' the audit asked if staff were receiving 'X6 supervisions per year? Records to evidence? Team meetings occurring regularly – minutes taken'? This had not been answered and no comments had been recorded for October 2015. The audit for October 2015 also recorded Y against 'Accidents and incidents logged and clear audit trail in service users file?' This did not concur with the evidence we found. When we saw reporting in daily notes of people's bruising or skin flaps we asked to see reports of the incidents and accidents. However these could not be located. The manager advised us they could be in a pile of their paperwork awaiting to be filed. When they had a look through their paperwork these could not be located. We were unable to establish if these had been completed or not. No analysis of incidents and accidents was taking place, which meant no learning was taking place from these incidents/accidents. It was clear there were no effective processes in place to ensure a good quality service was being delivered.

The lack of effective systems or processes to assess, monitor and improve the quality of service was a breach of Regulation 17 of the Health and Social Care 2008 (Regulated Activities) Regulations 2014.