Black Swan International Limited

Park House

Inspection report

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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

Park House is registered to provide accommodation and personal care for up to 25 older people. There were 21 people living in the home at the time of our visit. This was an unannounced inspection. The service also provided three 'beds with care'. This is a system where a home works with the hospitals to supply beds for people on a temporary basis for reablement or palliative care. There are qualified nurses who visit these services regularly to provide further support to the care staff.

There was not a registered manager in post. 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 current manager was in the process of undergoing the registration process through CQC, and had been in post since May 2016.

Staff understood what protecting people from harm or abuse was, and this was reflected in training records. Staff understood their roles and responsibilities in keeping people safe and actions were taken when they were concerned about people's safety. People were safely supported to take their medicines by trained staff.

There were detailed risk assessments within care records concerning risks associated with individuals. These included guidance for staff on how to mitigate these risks. Staff were confident in reporting incidents and accidents should they occur. The appropriate checks and maintenance in relation to people's living environment were carried out. There were effective processes in place to minimise risk of harm.

Safe recruitment processes were in place to ensure that people employed in the service were deemed suitable for the role. There were enough staff to keep people safe.

People told us and our observations showed that staff were kind and caring. Staff had good knowledge about the people they cared for and understood how to meet their needs. Feedback from people and their relatives about the care they received was complimentary.

People planned their care with staff and relatives, and staff respected privacy and dignity. People were supported to access healthcare wherever necessary and in a timely manner, with prompt action taken in response to changes to a person's health needs.

Staff supported some people to follow their interests and hobbies. There was regular visiting entertainment; however there was not as much stimulation for people who preferred to stay in their rooms.

People received enough to eat and drink, and received specialist diets in line with recommendations such as speech and language therapy. Food and drink was available throughout the day, and people received a good choice of meals. Staff also supported people to have their own food and drink which they purchased

themselves when they wished.

Staff understood the importance of gaining people's consent to the care they were providing to enable people to be cared for in the way they wished. Some people had authorisations applied for the lawful deprivation of their liberty (Deprivation of Liberty Safeguards (DoLS) and staff were able to explain how they promoted choice where people had variable capacity. The home complied with the requirements of the Mental Capacity Act 2005 (MCA).

Staff were motivated and spoke positively about their job and understood the importance of providing a high standard of care to the people living in the service. Staff told us that there was good teamwork within the service, and that they felt supported in their roles.

The service had quality assurance systems in place to assess, monitor and improve the service. These included auditing systems and ways of gaining feedback from people about the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by a sufficient number of competent staff, who were aware of their responsibility in protecting people from harm.

Risk assessments were in place for individuals and their environment and these were followed to minimise avoidable harm.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff sought consent, and people were supported to make their own choices.

People had timely access to healthcare services and staff followed advice given from healthcare professionals.

People received a good choice of what to eat, and drinks were always available to people.

Is the service caring?

Good

The service was caring.

Staff were kind and caring towards people and their families.

Staff interacted with people in a patient and meaningful way that respected their privacy and dignity.

People were consulted about their needs.

Is the service responsive?

Good

The service was responsive.

Individual preferences were taken into account when planning

care, and records contained details of these. People were able to access activities and entertainment within the home.

Complaints and issues raised were acted upon in a timely manner.

Is the service well-led?

Good

The service was well-led.

Effective quality assurance processes were in place which helped drive improvement.

There was positive morale of the staff in the home, and an open culture whereby staff and people felt the manager was approachable.

Park House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 October 2016 and was unannounced. It was carried out over a day by one inspector 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.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During this inspection, we spoke with four visitors to the home, nine people who lived at the home, and three members of staff including the manager. In addition, we also spoke with the regional manager from the organisation. We spoke with two healthcare professionals who visited the service regularly.

We observed how care was delivered throughout the day. We reviewed care records and risk assessments for three people who lived at the home and checked five medicines administration records with associated audits. We looked at other records such as staff training records, and reviewed information on how the quality of the service was monitored and managed.

Good

Is the service safe?

Our findings

People we spoke with who lived in the home told us they felt safe; one person said, "Yes I feel safe, there is a proper alarm system". Another person confirmed this, saying, "I'm very relaxed when I'm with [staff], I feel safe".

Staff understood how to protect people from harm. Staff were able to tell us that they had training in safeguarding and were able to tell us what types of abuse there were. The manager of the home had referred relevant notifications to the appropriate safeguarding authorities where necessary. Staff told us they felt comfortable to raise concerns to the manager or provider if they felt they needed to, and how they would report any incidents relating to poor practice or abuse. This was supported by appropriate safeguarding and whistleblowing policies and indicated that the organisation had appropriate processes in place to promote people's safety.

Care records documented individual risk assessments for people covering issues such as moving and handling, health conditions, tissue viability and individual fire risk assessments. We observed people being assisted to mobilise safely in line with care records, using equipment appropriate to the person's need. We saw that there was guidance in place for staff to follow which minimised risk. Accidents and incidents were reported and acted upon appropriately and in a timely manner and staff told us how they reported them. The service took steps to effectively manage individual risks, and there was a comprehensive system for recording any incidents or accidents.

A healthcare professional who worked with the home told us that staff were competent in picking up any areas of risk, such as a suspected infection or pressure areas. Staff told us about what concerns they would report with regards to people's skin if they were at risk of developing a pressure area. We saw that where people required support to reposition, they received this from staff and it had been recorded. However, there were some people living in the home who refused this support, and this was documented. This meant that systems were in place for preventing and acting upon pressure areas where people were at risk.

We found that equipment for detecting, preventing and extinguishing fires was tested regularly. All of the electrical equipment in the home had been checked for safety. A gas safety check had recently been carried out, and the regional manager told us what checks they had in place for water safety and the prevention of legionella. We saw that lifting equipment was serviced as required and environmental maintenance and associated risk assessments were in place.

We received mixed feedback from people about staffing levels. One person told us, "If I press my buzzer they come quickly." Another person said, "I think there is enough staff, they come to you regularly". This was confirmed by another person. However, another person said, "They come practically straight away when I ring my bell. Except in the mornings when they are getting everyone up". Again, this was reflected by another person we spoke with. We concluded from our conversations with staff and people that some people waited a bit longer in the mornings when staff were busier, however they said it was not problematic for them. There were enough staff to keep people safe.

We observed that the home had a strong core staff team and was able to use their own staff a lot of the time when they need extra support due to absence. The manager told us that when they had agency staff come in, they tended to be the same people that returned to the home. This meant that there was as much consistency as possible for people living there in terms of who provided their support.

Visitors to the home said that they had not had any concerns about staffing levels and the availability of staff to provide support and assistance when needed. During our visit, call bells were responded to promptly and we observed that there were staff present in communal areas during the day. The service used a dependency tool, as dependency needs changed regularly. This was used to calculate the hours of care required to meet people's needs. The rota we saw confirmed staff numbers that the manager had told us.

The provider's recruitment policies and induction processes were robust, and appropriate checks were made such as a criminal records check, and references sought. This showed that only people deemed suitable were working at the service.

Medicines were stored, managed and administered safely by staff who were trained to do so. The medicines administration record (MAR) for each person contained a front sheet with a photograph to aid staff in identifying people when administering medicines. There was also detail of any allergies. This meant that the risk of staff giving the wrong medicines to people was minimised. We checked five records and saw that there were no gaps in the records. We checked the records for medicines which were associated with higher risk, and therefore needed to be signed off by two members of staff. We also checked a random sample of medicines that were not in blister packs. We found that the balance corresponded with the amount received and given.

We observed staff offering additional medicines to people who had been prescribed 'as required' medicines. There was a protocol in place for this as well as an additional recording sheet, so that staff could document the time it was given and the reason. This meant that any risk of these medicines being taken too close together was minimal. Care staff supported people with applying creams and lotions and completed appropriate records and body charts. Medicines were sometimes given within a communal area, but we observed staff to be discreet when administering and discussing them.

Medicines management, in terms of ordering, returning, storing and administering, was audited regularly to ensure that people had received treatment as the prescriber intended, and any errors were picked up on. Where there had been an error, it had been investigated. There were auditing systems which were carried out regularly and picked up any errors. The manager carried out in-house medication audits and staff had reported and recorded any errors which the manager acted upon appropriately. We noted that when they identified concerns, prompt action was taken to address them.

Good

Is the service effective?

Our findings

People told us that staff were competent. One person said, "Yes, they help me get up." A relative told us they had confidence in the staff, and said, "[Relative] is being cared for very well, [relative] seems to be happy, always clean". Staff were able to tell us how they met each individual's needs. Staff were able to give examples of individual preferences which correlated with information in people's care plans. This showed us that staff were equipped with the knowledge to deliver effective care to people.

We spoke with the manager about new staff inductions, which they reported including shadowing, training and supervisions. New staff had the opportunity to complete further qualifications such as the care certificate. This is a qualification outlining a set of standards which care staff are expected to adhere to. Staff confirmed that the manager had checked and signed off their competencies before they were able to work alone with people.

Staff told us that they had received additional training to further enable them to meet the needs of the 'beds with care' provision. These are the beds which the home supplies for care for people recently discharged from hospital. They confirmed that the additional training included taking people's blood pressure, urinary tract infections and pressure area care. Staff also received training in dementia care. Other mandatory training included manual handling, infection control, food hygiene, safeguarding, first aid and fire safety. Senior staff completed training in care of medicines and the manager checked their competencies before they were able to do this. Training had been delivered via classroom face to face learning, paper work and via the computer. Staff told us that they found face to face training more useful, and the manager informed us that they had listened to staff and more face to face training was being organised. We were confident that the service offered learning opportunities for staff to be competent in their roles.

The service had champions in place to specialise in certain areas such as infection control and dementia. The regional manager told us that they had organised further training in nutritional screening for two members of staff, as they did not currently have a champion in this area. This demonstrated they were looking to improve care standards in ensuring people at risk of not eating and drinking enough were well supported.

All of the staff we spoke with said that they received supervision regularly. This is a formal meeting with the manager or senior staff, where care staff can discuss their role and any concerns or further training needs. They said that they could discuss anything, and the manager and their seniors were approachable for support at any time.

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). We checked whether the home was working in line with the MCA.

During the inspection we observed consent being sought when staff were delivering support to people. Staff were able to tell us about different people's capacity. We saw a mental capacity assessment which had been carried out for one person, and that this was thorough. Where people lacked capacity to make decisions, and were being deprived of liberty for their safety, the manager had applied for a DoLS authorisation. We could see that, whilst awaiting authorisation, decisions were made in the least restrictive way possible, and in the person's best interests.

People, visitors and staff told us that the food was of a good standard at the home. One person said, "The food is marvellous." We saw that drinks were available to people throughout the day, people had drinks in their rooms. We observed lunchtime, and saw that people had a choice of drinks with their meals.

People received a good choice of food that was available throughout the day. One person said, "The food is very good, if I want a packet of crisps or a banana I just ask and it's here". Another confirmed this, saying, "Well we have good meals, lovely lunch, choice. I was talking about brown bread one day and since then, they have always given me brown bread, it's much tastier". One person suggested that more fresh fruit for pudding could be provided. We spoke with the chef and they told us how they prepared meals for people on softer diets or who required specialist diets. They said that if someone did not want what was on the menu, they would make them something else. Staff also supported people to have their own food and drink which they purchased themselves when they wished. Speech and language recommendations for softer diets were documented in care plans and we observed that they were followed. The home had been awarded five stars for food hygiene.

A person told us, "They weigh me once a week, they bring the chair in". Another person explained how staff had responded to their change in weight, "At the moment I'm losing weight, even though I'm eating everything, I'm going for a scan". Staff recorded people's fluid and food intake when they were deemed to be at risk of not eating or drinking enough. People were regularly reassessed for their nutritional needs and we looked at the records which confirmed this in the care plans. The service met people's nutritional and hydration needs well, and the relevant information was available to healthcare professionals and staff when they needed it.

People had support to access healthcare when they required. One person explained, "Yes they make appointments for us with dentist, doctors, opticians, whatever we need". Access to healthcare was well documented with visits from district nurses, GPs and chiropodists. We saw in one person's records that the community falls team was involved in their care, as well as details of any appointments. The staff also explained how they worked closely and shared knowledge with the nurses who visited to provide nursing care for the provision of beds with care.

Good

Is the service caring?

Our findings

One person who lived in the home told us, "The [staff] couldn't do more if they tried." Another person told us, "Staff, I couldn't wish for a better lot, friendly, very helpful, they are so lovely". One staff member told us, "I treat people like family." This was echoed by all of the staff we spoke with.

People told us they were treated with respect, one telling us, "[Staff] are very respectful with personal care." Another person confirmed this, "They treat me very well, they treat me with respect. Sometimes if I'm having a bit of a problem they will do anything for me, cut my nails".

One person told us about the approach of staff, "Staff are great, very kind to me, make me laugh, have a lovely attitude, always smiling." Staff told us about people's communication needs. Where one person was unable to verbalise requests, they explained how they used the person's communication book, to get to know the person. One staff member we spoke with explained some different approaches they used to communicate with people. They said that with some people, they would make sure they used a softer tone as they knew they responded well to this. They also said it was important to get down to people's eye level if they were sitting down. We saw during our visit that staff adapted their communication according to who they were speaking with, and spoke softly and reassuringly to somebody who appeared to be distressed. They used an appropriate and reassuring touch with the person. We concluded that people and staff had built positive relationships, and that staff were caring and kind towards people.

One person said that staff supported them with personal care, but encouraged them to do as much as they could themselves. Staff were able to tell us how they encouraged choice, including with people who had varying capacity to make decisions. This included supporting them to choose from some outfits in the morning, and what they wanted to eat. They added that they always asked if people would like jewellery during personal care. This helped people to maintain some independence and control over their lives.

People said they were involved with decisions about their care, and a relative said, "They usually consult you about things, our two sons keep in contact with the staff in the office". This was confirmed by a relative who said, "They keep me updated on [relative's] health." The manager said that they met with everyone in the home to review their care. They also explained how they involved family members by having a meeting with them initially and consulting the person and their family, about their care.

Staff supported people to maintain close relationships with their loved ones within the home. One person told us, "My daughter comes on a Saturday and takes me out, she can come when she wants, there are no restrictions on that, she is made very welcome". A visitor said, "I come every day if I can, I'm always made welcome here". Another visitor told us how the staff always greeted them kindly and offered them a drink and lunch. Staff and people told us that visitors came when they liked, and that people could come and go with their families as they pleased.

We received mixed feedback about people's privacy. One person told us staff did not knock on their door. However, another person said, "Some [staff] knock on the door before they come in". During our visit, we

saw that staff knocked before going into anybody's room. People did say that staff were always respectful of their privacy when carrying out any personal care. One person explained, "[Staff] put a big towel over my front and always make sure the curtains are closed." Staff were able to tell us how they supported people's privacy and dignity by covering them up, reassuring them and talking to them throughout any care.

We noted that during our visit that some healthcare visits were carried out in the communal areas of the home, including visits which involved taking people's blood for testing. The person receiving treatment, and the people around, were not consulted about whether or not they preferred for this to be carried out in private. A further healthcare professional we spoke with confirmed that they carried out treatment in communal areas, and that people were not consulted about this. This compromised people's dignity and privacy. We concluded that staff supported people's privacy when delivering care, however there was some compromise concerning the provision of additional healthcare visits.

Good

Is the service responsive?

Our findings

There was a variety of visiting entertainment which some people enjoyed, including musicians and a magician. One person said, "I like the country and western singer." The home had also held a Summer BBQ and planned other events throughout the year such as at Christmas and Halloween. There was an activities timetable in place, which included board games and poetry reading. One person also gave an example of an event the home put on for them, "They gave us a celebration party downstairs for our 60th wedding anniversary, we had 14 family members here." People said they were able to spend time in their rooms if they wanted. One person told us, "It's my piano downstairs, I go and play for them sometimes. I love music, I write it, I have my computer, I listen to my music. I can see staff as they walk back and forth, they come and chat."

We received mixed feedback regarding the extent to which people were able to follow their interests, "I like to sit and do knitting. I go downstairs to have my hair done. It depends on what's on." Another person gave us examples of activities and entertainment, "We do knitting, we have singers, one I love is a man who does classical guitar, he comes quite often, we have Elvis impersonators". Another person told us that they enjoyed knitting, and that their family bought the equipment to them. We asked if staff supported them to knit when their family were not around, and they said they did not. Someone told us, "Our entertainments manager retired but I don't think she has been replaced."

Staff supported some people to go out to the shops or for lunch. One person said, "You do get bored." Some staff said that there were times when they were busy and not able to spend extra time with people to have conversation. Staff did say, however, that they usually had time in the afternoons. One staff member explained how they spent some extra time with someone who was cared for in bed, and therefore was not able to engage in activities outside of their room. They said that they would talk to them and put the radio on for them, as they knew what music the person liked. We concluded that staff spent time with people when they had time, however some people felt that there was not enough to do. We saw the activities timetable for the week and it included hairdressing and nails. We found that the timetable did not always reflect everyone's interests, and that there was not designated time for staff to deliver one to one time with people in their rooms.

One person had also said in a recent meeting for people living in the home, that they would like for a dog to visit. The manager told us that they were looking into this possibility and to arrange it if they could. Some people and visitors commented that the lounges always had televisions on and they did not always want this. When we spoke with the manager about it they said that some people wanted it on, so it was difficult to meet everyone's preferences. The regional manager said they would look at developing a quiet lounge area with no television. The staff we spoke with said that it would be nice to have more time to take people out and spend one to one time with people more often.

People told us that staff were responsive to their needs. One person told us, "[Staff] ask me what I like." Another told us how all the staff paid attention to detail, saying, "The [cleaner] will do anything for me, take my plants and water them, if I have fresh flowers they will top the water up."

One person also explained how they found staff responsive, and how they felt this had improved, "One time they used to take us [to the bathroom] in turn so we knew when we were going, just before dinner, just before tea, but there were times we wanted to go out of turn. Now I just wave and get attention, always staff around, they are fairly quick to respond." We did see that in one lounge there were five people, who had restricted mobility. There was not an alarm available to all of them. Although we saw staff around in the communal areas at intervals throughout the day, it was not always possible for someone to attract staff's attention if they needed something. Some people told us that they had to wait longer in the morning at times, as staff were busier then.

Individual care needs had been assessed prior to admission to the home, which ensured that people were able to live in a suitable environment for their needs. We looked at some care plans, which included people's views and religious beliefs. The service maintained some links with the local community and there were visits from the local church for Holy Communion. However, there were some people who said they would like to go out to church. We spoke with the manager about this and they said they would find out more and arrange this for them.

People's care records were concise with details of the person's preferences and dislikes. One person explained to us that they had been given a choice of male or female carer. Each person's care needs were documented to provide staff with information about what support people required and how they preferred to receive care. They also had information about people's interests and life histories. We saw that one person had communication difficulties. These were well documented within the person's care plan and staff were able to tell us how to communicate with the person, and their likes and dislikes. However, we found that the care record did not contain full guidance about one aspect of the person's care regarding a specific health need. We discussed this with the manager and they said they would gain more specialist advice on this and update the care plan with this in mind. Staff told us that they found care records useful, but normally communicated need through the handover meetings, where they discussed people's requirements between each shift.

Where people were accommodated using the beds with care, the home worked closely with the hospital team and the families to put together a care plan of what care people needed. One visitor told us that the staff had asked them about their relative's preferences when they came into the home. The manager told us they had organised a meeting with the family to discuss the person's on-going needs.

People said that they knew how to make a complaint, "If I wanted to change something all I'd have to do is ask [staff member] they are lovely we have a laugh, or [manager]." This was reflected by all of the people we spoke with, and one added, "They did listen to us when we had a complaint." People were asked for their feedback on the service, one person saying, "They send us questionnaires every so often." Another person said, "We have a meeting with the governors, don't go very often, what it is they ask you questions how things are but I haven't got any grumbles."

Good

Is the service well-led?

Our findings

One person said, "[Manager] is lovely, they will always listen to you". A visitor said, "The manager is so approachable, I don't know how they do it, seems to spend all hours of the day here". One member of staff told us, "[Manager] helps you a lot." There was good leadership in place. Staff we spoke with said that the manager often helped the staff on shift in delivering care. During our visit the manager was administering medicines. This showed us that they were involved in direct delivery of care to people and supporting the staff team.

The manager had recently placed an additional member of staff on in the mornings following recent feedback that staff felt they were rushed on these shifts. This showed us that the management team listened to staff and acted upon concerns.

They said that when they started working at the home, they had gone through everyone's care plans with them and focussed on the life histories, in order to further get to know people. We observed that the manager was visible throughout the home and people knew who the manager was.

Staff we spoke with said that there was good team work and that they were well supported by everyone. The manager confirmed that they received a lot of support from the regional manager from the organisation, and so felt well-equipped to do their job well. There was also a deputy manager in post. A healthcare professional we spoke with told us they had noticed that the team was improving and working together better since a new manager was in post. Another healthcare professional we spoke with who had visited the service over a long period of time, felt that the manager was making positive changes to improve the service. This demonstrated to us that good leadership was in place.

There were a number of audits in place which monitored the service for quality. These were carried out by the manager, the regional management team, senior staff and visiting staff from other homes within the organisation. Audits carried out included a senior management audit, which covered staff recruitment, reviews of care records, meetings, and competency checks for staff. An additional manager's audit was carried out monthly which included checks that new staff inductions were taking place, staff training and equipment maintenance were all up to date. Audits were also carried out in health and safety, medicines and infection control. The audits we looked at had included ongoing action required, and this would be checked during the following audit. The meant that the service was committed to picking up potential problems and taking action going forward. We were confident that systems were in place to assess, monitor and improve the service.

There were quality assurance methods, in addition to seeking feedback from people living in the home, such as a staff survey. Records showed that meetings took place for people living in the home on a quarterly basis, involving a member of the regional manager. Records showed that people were consulted about aspects of the home such as activities. We saw that whilst these were discussed with people, they had not always been acted upon or resolved appropriately. We discussed this with the manager, with regards to the provision of activities and supporting people to follow their interests. For example, the person who

suggested in the last meeting, that a dog visited the home, had not been followed up. The same person said that they still would love this to happen, and they had not received any further feedback on their idea. Other people told us they wanted to go out to church, and be supported to follow interests, and this had not been picked up by quality assurance systems. The manager and regional manager acknowledged this and said they would improve communication following the meetings, and work on gaining feedback from people.

They also received support from the hospitals team, which also helped the home keep up to date, for example regarding guidelines around urinary tract infections and pressure care. A health care professional we spoke with told us that they felt the manager was responsive to recommendations and sharing knowledge with other organisations.

The manager told us that the organisation was supportive, and that they received ongoing support from their regional manager.

The manager was aware of what notifications they need to send CQC and other organisations such as the local authority, and these had been made appropriately.