Mr & Mrs T F Chon

Parkside Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 9 and 10 January 2017 and was unannounced. When we last inspected this service on 12 July 2016, we found significant shortfalls in the care provided to people. At that inspection we found the home was in breach of eight legal requirements and regulations associated with the Health and Social Care Act 2008. We found that risk assessments were not in place to protect people from harm and medicines were not being managed safely. Mental capacity training and assessment had not been carried out in accordance to the Mental Capacity Act 2005 (MCA). We also found training was not being carried out consistently. Some people's food intake was not being monitored and actions plans were not in place for people at risk of malnutrition. Some care plans had not been completed in full and complaints had not been appropriately dealt with.

Parkside Residential Home is a residential home for up to 30 adults with dementia. There were 28 people staying there at the time of the inspection.

The home had a registered manager in place during our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Improvements had been made with the management of medicines and medicines were now being managed safely. People were receiving their medicines on time and as needed medicines when they needed them. Medicines were stored securely and systems were in place to order from, and return medicines to, the pharmacist. Dispersible tablets or liquid medicines were given to people with swallowing risks. Medicines records were being completed and were up to date. Training had been delivered to staff on managing medicines and staff had been competency assessed.

Risks were being identified and preventative measures put in place to prevent the risk of health complications. However, risk assessments had not been made specific to some people's circumstances and health conditions. Risk assessments relating to falls and skin integrity were identical and not person centred.

Quality assurance monitoring was in place which identified issues and prompt action was taken to make improvements where necessary. However, the audits had not identified the concerns we found with risk assessments.

The home had adequate staffing levels. We observed that staff were prompt in supporting people and call bells were being answered within acceptable time limits.

Improvements had been made in assessing people's capacity to make decisions on a particular area. MCA assessments had been carried out assessing people's ability to make decisions. Staff had received training

in MCA. Staff that had not received training had been booked to receive this training. Most staff we spoke to were able to tell us about the principles of the MCA and how the test was applied to determine if a person had capacity to make a specific decision about their care.

Deprivation of Liberty Safeguarding's (DoLS) applications had been made to deprive people of their liberty lawfully in order to ensure people's safety. CQC was notified of outcomes of DoLS applications.

Food and fluid intake was being monitored for most people with specific health concerns and appropriate intervention had been made to ensure people were at best of health such as referral to dieticians and GP.

Supervisions were being carried out with staff and staff told us that they were supported.

Staff had received essential training and had been booked into training they needed to do their jobs effectively. Staff had received an induction when starting employment.

The provider had submitted an action plan to the CQC to address the breaches identified at the last inspection.

Surveys were carried out and analysed to ensure people received high quality care and improvements were made as a result.

Staff were aware on how to manage complaints and we found complaints received since the last inspection had been investigated and appropriate action taken.

People told us they felt safe. Staff knew how to keep people safe from abuse. They knew how to recognise abuse and who to report concerns. Staff knew how to whistle blow. Whistleblowing is when someone who works for an employer raises a concern which harms, or creates a risk of harm, to people who use the service.

Safe recruitment and selection procedures were in place. Checks had been undertaken to ensure staff were suitable to work with people receiving care.

We observed caring and friendly interactions between people, management and staff. There was an activities programme in place.

People were encouraged to be independent. People were able to go to their rooms, go outside and move freely around the house.

Overall, we found improvements had been made with medicines management, complaints, notifications, staffing, consent, record keeping and quality assurance. We identified a breach of regulation relating to risk management.

As the provider has demonstrated significant improvements and the home is no longer rated as inadequate for any of the five questions, it is no longer in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Some risk assessments were not updated to reflect people's current circumstances and health needs.

Medicines were being managed safely.

There was adequate staffing to care and support people.

Staff knew how to identify abuse and the correct procedures to follow to report abuse.

Recruitment procedures were in place to ensure staff members were fit to undertake their roles.

Is the service effective?

Good

The service was effective.

People's rights were being upheld in line with the Mental Capacity Act 2005 (MCA). DoLS application had been made.

People were being referred to health professionals if they were at risk of malnourishment.

Supervisions were being carried out with staff. Staff told us that they were supported.

People had access to healthcare services and had been referred to healthcare professionals to ensure that they were in the best of health.

Is the service caring?

Good

The service was caring.

Staff had a good knowledge and understanding of people's background and preferences.

Staff treated people with respect and dignity.

People were encouraged to be independent.

Is the service responsive?

Good

The service was responsive.

Care plans included people's care and support needs.

Complaints received since the last inspection had been investigated and actions taken to resolve the complaint.

There was an activities programme in place. People were also able to go outside and attend theatres, garden centres and visit children at school.

Is the service well-led?

Requires Improvement

Some aspects of the service was not well-led.

We have not changed the services' rating from 'Requires Improvement' because to do so requires consistent and sustained improvement over time. We will check this during our next planned comprehensive inspection.

Regular audits were being carried out that identified issues and action taken to make improvements. However, the audits had not identified the concerns we found with risk assessments.

Surveys were being analysed and used to ensure people received high quality care.

People, relatives, staff and health and social professionals were very positive about the management.

Staff and residents meetings were being held.

Parkside Residential 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.

The inspection was carried out on 9 and 10 January 2017 and was unannounced. The inspection team comprised of two inspectors 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 relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people.

During the inspection we spoke with seven people, two relatives, a community matron, a medical consultant from the local hospital, a community psychiatrist consultant, a health care assistant, a rehabilitation nurse and a social worker. We also spoke with the registered provider, registered manager, activities co-ordinator and four care staff.

We observed interactions between people and staff members to ensure that the relationship between staff and the people was positive and caring. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

We spent some time looking at documents and records that related to people's care and the management of the home. We looked at nine care plans, which included risk assessments.

We reviewed five staff files which included training and supervision records. We looked at other documents held at the home such as medicine records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at the home. Comments from people included, "I've not seen any unsafe things", "Yes, I've been okay", "I do feel safe. I am happy here", "I've been safe, I've never been worried about anything" and "I'm safe and okay here." Relatives told us, "Generally [person] has been safe here" and "I was unhappy about [person] safety, but not anymore. [Person] was falling over last year but not since the manager came, she is on the ball." A social care professional told us about the person they visited, "[Person] is happy here" and a rehabilitation nurse told us about the person they had treated, "[Person] seems fine." A community psychiatrist consultant told us, "It's been very good, no concerns about the home and level of care."

During our last inspection the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had not completed risk assessments specific to people's health conditions and circumstances. At this inspection, we found that the provider had not fully addressed this issue. We found although risks had been identified and risk assessments were in place, some risk assessments were not specific to people's circumstances and health.

Risk assessments had been completed for people at risk of bruising due to blood thinning medicines and for people who had osteoporosis. One person's osteoporosis risk assessment detailed that the person exercised regularly to strengthen the bone area in their knee. We observed that a member of staff carried out this exercise with the person ensuring the person used their knee to lift light items with their feet.

Assessments had been made when people required support with moving and handling that listed people's ability to move, the support required and their height and weight, which then determined the risk levels. These assessments had been completed in full.

There were general assessments for everyone such as safety awareness, falls, unsupervised wandering, physical/verbal aggression and absconding. This had been completed in full on the care plans we looked at.

The home worked closely with the Care Home Assessment Team (CHAT) and a medical consultant from the local hospital who undertook falls clinic for people at risks of falls. This included carrying out a health assessment and identifying if people were at risks of falls. The community matron from the CHAT team told us that training in falls prevention had been scheduled for 17 January 2017. The community matron told us, "They engage 100 per cent with us." The medical consultant told us that the home would follow up on actions recommended by them to ensure people maintained good health.

A falls risk assessment had been created for one person at risk of falling. However, the mitigating factors listed on the risk assessments were identical to other people living at the home identified to be at risk of falls. Although the assessment listed ways to prevent falls and what to do if someone fell, it did not elaborate on what caused the person to fall. The person's care plan noted that they were unsteady on their feet when mobile and staff should ensure the person used their walking frame and be supervised. This information had not been included on the risk assessment. For another person, their risk assessment did not include if the

person was at risk of falling as the person was reluctant to use their walking aid but this had been included on their care plan. We spoke to the two people who were at risk of falls and they told us that they felt safe and had not had a fall since staying in the home. A person told us, "No, I've not had a fall." We observed throughout the day that staff were prompt when people that may be at risk of falling wanted to get up or needed assistance when mobile.

Skin integrity was assessed using Waterlow charts to determine risk levels. For two people who were identified as being a very high risk with skin complications, a risk assessment had been created. However, this was identical to the risk assessments for other people living at the home also at risk of skin complications. The risk assessment identified that both people should be turned every two hours when in bed and appropriate equipment was in place to minimise the risk of skin complications. Records showed that re-positioning was completed every two hours and a pressure mattress and pressure cushion was in place.

For one person who was identified as being a very high risk of skin complications, a risk assessment had been created identical for other people living at the home also at risk of skin complications. The Waterlow chart detailed that the person's skin was broken. The person had been admitted to the home with pressure ulcers. The risk assessment in place did not detail where the broken skin was and what treatment and action was required. The registered manager told us the ulcer was in the person's leg and the leg needed to be elevated. We were informed the pressure ulcer had healed but this was not included on the plan. In addition, we found four people that were identified as high or very high risk of pressure ulcers. A risk assessment had not been created to provide guidance to staff to minimise the risk of serious skin complications. The registered manager told us the visual checks showed these people's skin were not discoloured or broken and records confirmed this. The risk was due to other factors such as the person's health condition, mobility, gender and age. The registered manager said that if people's skin was found to be dry or thin then they were referred to the GP and creams were prescribed for application which was confirmed by records seen. Records showed that the Waterlow assessments were completed monthly and as part of this people's skin was checked.

Staff were able to tell us how to prevent and manage pressure ulcers such as reporting any redness in people's skin, repositioning regularly and keeping people mobile and hydrated.

A person with a diagnosis of epilepsy had a risk assessment completed which explained what epilepsy was and the action staff should take if the person had a seizure. Although the risk assessment detailed that staff should be aware of the triggers, the triggers for this particular person had not been included on the risk assessment. We were informed the person had not had a seizure since being admitted to the home and their condition was controlled through medicines.

Another person had been assessed as being at risk of depression, the risk assessment was generic and did not provide any detail as to how their depression affected them, the behaviours that they may demonstrate and how staff were to support them to reduce or mitigate the risk.

Another person was at risk of displaying verbal aggression. There was no information on the risk assessment how the person behaved when being verbally aggressive, what the triggers were and what de-escalation techniques could be used for that person to calm them down. However, when we spoke with the registered manager and staff about this they were able to explain the triggers and techniques they would use but this had not been recorded. We observed that the person displayed behaviour that may challenge and staff reacted promptly and used good de-escalation techniques to calm the person down.

There was a risk assessment in place for two people that assessed the level of risk with regards to their dementia and associated behaviours. Records showed that one person was high risk in all areas and one person was high risk in some areas. However, a summary of the risks and levels of risk was not completed to ensure how risks that were identified could be mitigated.

Although people's risks were being identified and preventative measures were in place such as referrals to falls clinic, pressure relieving equipment's and staff knowledge, the information was often generic and did not always look specifically at how risks were to be mitigated for that particular person. This meant that advice to staff was generally the same in each risk management plan relating to falls, skin complication, behaviour and depression. The information did not always take into account how the person's behaviour or health condition might alter the level and type of risks. This meant that people may not receive specific support and care that may be needed to mitigate the risks of health complications.

The above issues related to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

During our last comprehensive inspection on 12 July 2016 the service was in breach of Regulation 12 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found medicines were not being managed safely. A warning notice was served to ensure medicines were managed safely. We carried out a focused inspection on 9 November 2016 and found medicines were being managed safely and the home had met the requirements of the warning notice. During this inspection we checked medicines to ensure the improvements had been sustained. The community matron from the CHAT team told us that the home had made improvements with medicines.

Systems were in place for obtaining medicines. The registered manager was able to tell us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them.

As part of this inspection we looked at the medicine administration records for 12 people. The records we reviewed were clear and had been signed to confirm people had received their medicines. The records showed people were getting their medicines when they needed them and any reasons for not giving people their medicines were recorded. A person told us, "I get medication regularly every day." Another person told us, "They give me my medication." We also saw the provider did weekly audits to ensure the administration of medicine was being recorded correctly. Records showed that concerns were highlighted and action was taken to investigate and address these concerns, such as gaps in recording people's medicines. Outcomes of medicines audits were also discussed in team meetings. We counted people's outstanding medicines against the medicine records and concluded that people had been receiving their medicines as prescribed.

Medicines were stored securely and we observed that the medicines trolley was locked at all times when unsupervised. A person told us, "I self-medicate and all my medication is locked up in that cabinet."

For people at risk of swallowing, the registered manager had ensured that an agreement with the doctor had been made to prescribe dispersible tablets or liquids. For one person who had swallowing difficulties and needed their medicine crushed and diluted to be administered covertly, there was written agreement obtained from the GP. During our last comprehensive inspection we found tablets that were supposed to be crushed in half were not being crushed and a person had been given the full tablet to swallow placing the person at risk of choking. During this inspection, we found that agreements had been reached with the pharmacist to ensure any tablets that were to be crushed in half were done by the pharmacist and placed in a blister pack for administration. Appropriate equipment was in place to measure liquid medicines in the

form of pods, spoons and syringes.

People were receiving PRN medicines and records showed that people that were in pain had received pain killers. The registered manager told us she had contacted the GP to ensure PRN medicines were in blister packs for people that would need PRN medicines on a regular basis. For people that could not communicate verbally, the registered manager told us they assessed pain through people's behaviour, body language and facial expressions. There were also pictures in place to communicate with people should staff suspect if there were in pain.

Any medicines no longer required by the home were returned to the supplying pharmacy at the end of each monthly cycle. We observed the medicine room had been relocated and the room was organised and there was only a small amount of medicines to be returned. The registered manager told us that medicines were returned within seven days. Systems were in place to return medicines, which recorded the person's details, type of medicine, quality and reason for disposal.

The medicines fridge temperature was being monitored and recorded daily within the recommended temperature range. Records showed that the medicines fridge temperature had not gone out of range since August 2016.

Two people self-administered their medicine. This was managed appropriately with signed consent forms in place and a completed risk assessment.

We saw all care staff who administered medicines had undergone training in July 2016 and competency assessments had been completed by the registered manager. New members of staff had undergone medicine training and had competency assessments to ensure there were able to administer and manage medicines safely. The competency assessment form had been created with the support of the CHAT team.

Controlled drugs were stored and managed appropriately. One person was prescribed a controlled drug and accurate records were maintained, which included the person's name and administration details. A second trained member of staff counter signed records to confirm administration.

During our last comprehensive inspection the home was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We observed that people were left unsupervised for long periods of time, the manager was heavily involved with providing personal care and staff, people and relatives had expressed concerns with staffing levels.

At this inspection we found that the provider had addressed this issue.

During this inspection, most people told us that there were sufficient staff to support and care for them. One person told us, "There seems to be enough staff." Another person told us, "I think there are enough staff." The home employed four care workers during the morning and four care workers in the afternoon. The care workers were supported by a cook, domestic staff, an activities coordinator and the registered manager. The manager assisted with medicine rounds and lunch if needed. The registered manager told us that staffing levels were appropriate as four people were independent and only few people needed specific support. We observed that call bells were answered promptly. A person told us, "The manager checked the call bell and staff responded in 30 seconds [when pressing it]." We did a test on the call bells over the two days of the inspection on each floor and found that staff response was within an acceptable time limit.

Some people used walking frames for support. Their care plans stated that they required supervision when

they were mobile. We observed that these people were being supervised at all times. The registered manager and staff told us that staffing was adequate. We observed that people received prompt attention when needed. Although a formal dependency assessment was not being carried out, people's care plan listed the amount of staff required for personal care and transfers. The provider and registered manager told us that they would be looking to recruit senior carers and a deputy manager to help the registered manager with managerial duties.

Weekly fire tests and regular evacuation drills were carried out. Fire risk assessments and fire safety audits regarding the safety and security of the premises were completed with follow up actions to minimise the risk of fire. There was a grab bag in place that included Personal Emergency Evacuation Plans (PEEPs) for all people and the names of people living at the home.

During our last inspection we found that three people who lacked mobility were living on the upper floors and risk assessments had not been completed on what to do in the event of an emergency. As the people lacked mobility they were unable to use the stairs and neither the lift in the event of an emergency. PEEPs had not been completed for these people. We did not see evacuation equipment had been installed to safely remove people during the inspection. During this inspection we found improvements had been made to ensure people were protected in the event of an emergency. PEEPs had been completed in full and listed what staff should do in the event of an emergency. PEEPs had been completed for people who were on wheelchairs living on the upper floors, which listed how these people should be evacuated. When we spoke to staff they were able to tell us how to evacuate these people safely. Appropriate fire safety measures and equipment had been installed to protect people in the event of a fire.

Appropriate gas and electrical installation safety checks were undertaken by qualified professionals. Checks were undertaken on legionella to ensure people living at the home were safe.

Staff had been trained in safeguarding adults. Staff were able to explain how to identify abuse, the types of abuse and who to report abuse to. Staff also understood how to whistle blow and knew they could report to outside organisations such as the Care Quality Commission (CQC) and the local authority.

We looked at five staff files and saw that the service had safe and effective systems in place to manage staff recruitment. The files contained the necessary documentation including references, proof of identity, criminal records checks and confirmation that the staff member was eligible to work in the UK. Any gaps in employment that were identified as part of the recruitment process was discussed with the staff member at the interview stage of the process.

The provider accepted DBS checks that had been completed by other providers that were less than six months old. The registered manager told us that they would do their own DBS check for those staff once they completed their probation. In addition to this the provider also asked the prospective staff to sign and confirm that they have not had any convictions.

The home had dedicated cleaning staff and we observed the home and people's rooms were clean and tidy. Staff used appropriate equipment and clothing when supporting people. All chemical items had been stored securely. People and relatives told us that rooms and the home was kept clean and tidy. A relative told us, "[Person] room is fine, they clean it every day." A person told us, "They clean the room and bathroom every day."

Good

Is the service effective?

Our findings

People and relatives told us that staff members were skilled and knowledgeable. One person told us, "Staff seem well trained" and another person commented, "Yes, staff seem well experienced." A relative commented, "The staff seem good at what they do." A social care professional told us, "They [staff] are supportive." A healthcare assistant told us, "The staff are very good, very helpful." A community psychiatrist consultant commented, "They [staff] are generally very good with dementia."

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 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.

During our last inspection the home was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that MCA assessments had not been completed in accordance with the MCA principles and MCA and DoLS training had not been provided.

At this inspection we found that the provider had addressed this issue.

DoLS applications had been made to the local authority for people who required supervision when going outside. This meant that people were being deprived of their liberty lawfully.

Staff told us that they asked for consent before providing care and support and people and relatives confirmed this. A staff member told us, "Yes, I always ask for consent, I have too." During the inspection we observed that staff asked people for consent before doing anything.

Training in MCA had been provided to staff. Most of the staff we spoke to were able to tell us the principles of the MCA. Only one staff member was unable to tell us the principle as they had started recently. The registered manager told us there were in the process of booking MCA training for staff that had not received training. We found that improvements had been made with MCA forms. The MCA forms covered the elements of capacity, namely can the person understand, retain, and weigh the information, and make a decision on the information. Records showed family members had been included on the assessment when required.

For people that self-administered their medicines, records showed that a capacity assessment was carried

out to check if they had capacity to self-administer medicines.

During our last inspection the home was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people's food and fluid intake was not being monitored when needed and people's weight was not being monitored routinely and action not taken if people were losing weight.

At this inspection, we found nutritional assessments had been completed, which included what type of food people liked. A nutritional risk assessment had also been carried out to identify if people were at risk of malnourishment and dehydration. Some people had high cholesterol, weight issues and diabetes and we saw people's weight and food intake was being monitored regularly. We found three people had lost weight. Where people had lost weight, we found their food intake was monitored and regular meals were being provided. The home had taken appropriate action such as referring one person to a GP and dietician and providing fortifying yogurts and supplements. In one instance, a person's weight had increased when the person was referred to a dietician and a supplement was provided.

For two people at risk of choking, referrals had been made to the Speech and Language Therapist (SALT) and there were swallowing safety guidelines with swallowing strategies in place, which included specific guidelines to support both people with their meals.

At the last inspection, we found two people's blood pressure was not being monitored routinely to minimise the risk of health complication. During this inspection, we found that the two people who were at risk of developing high blood pressure were having their blood pressure recorded monthly.

People told us that they enjoyed the food at the home and were well hydrated. People told us, "The food's quite nice, it's English", "I like the food here", "I do enjoy the food" and "We get enough to drink." A relative told us, "The meals are pretty good, plenty of choice."

Choices were offered to people and we observed that people were asked what they preferred prior to lunchtime by the cook. Records also showed that people were asked what they would prefer and people who were vegetarian were accommodated. A person told us, "The food's okay and you can have vegetarian meals." The menu offered two different types of meals. If people did not prefer the meals on the day then they were able to request an alternative. Observation and records confirmed this. A person commented, "There is choice and I'm okay with it. They always ask if I need water." Another person told us, "They have given me something else if I wanted." A relative commented, "When [person] wanted something particular, they did it for him. [Person] is kept well hydrated." The cook and staff confirmed people had choices during meal times. One staff member told us, "The cook asks what they [people] want to eat."

We observed that the kitchen was clean and tidy. Cooked and uncooked meat were kept separately. Labels had been used that detailed when a food item had been opened. There were food fortifying plans in the kitchen for people and also instructions on which food to avoid for people at risk of choking. We spoke to the cook who was able to tell us which people had specific diets and that specific meal plans were used to make people's food. The kitchen had been awarded an environmental hygiene rating of four out of five.

We carried out an observation during lunchtime. People were not rushed and we saw some good interactions between people and staff who communicated with people and encouraged people to eat. We observed that food was placed within easy reach of people. Drinks were available and were offered to people. Staff asked if people had finished their drink and meals before removing them. There was a relaxed atmosphere during meal times. In one instance we saw a staff member had praised a person for finishing

their meals and another instance a staff member sat with a person who was not eating and tried to support the person to eat. The person refused and this was respected. Staff explained what was in people's meal before serving. In one instance a person was trying to eat with a butter knife, however a staff member intervened and encouraged the person to eat with a fork and in another instance a person was feeling uncomfortable because of their clothing and a staff member supported the person to loosen some buttons on their cardigan to make them feel more comfortable.

We observed one person was demonstrating behaviours that may challenge with another person, staff responded promptly and spoke to the person in a calm way and separated the person from the other person. In one instance, a person expressed their choice and although this was not on the menu, the meal was still prepared and given to the person.

We observed that there was a delay of up to 20 minutes for one person's food in the dining area whilst other people had received their food and were eating. We fed this back to the registered manager who informed she would normally supervise meal times as part of the daily audits and assured us this did not happen and would not happen again.

During our last inspection the home was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that some staff had not received mandatory training to perform their roles effectively.

At this inspection we found that the provider had addressed this issue.

Each staff file that we looked contained records confirming that each staff member had received an induction prior to starting work.

There were systems in place to keep track of which training staff had completed and future training needs. Staff told us that they were able to request training, the types of training they completed and found the training helpful. Since the last inspection staff had completed training in mental capacity, manual handling, safeguarding, fire safety, first aid and common health conditions. Records showed that staff had been enrolled on refresher training in dementia, food hygiene, infection control and end of life care.

At the last inspection we found that the annual appraisal form did not list training and developmental needs and aims and objectives for the year ahead. During this inspection the registered manager showed us the template they used for supervision and appraisals. It was a template devised by Skills for Care. However, the completed forms did not confirm whether a supervision or appraisal had taken place. The registered manager informed this would be made clearer. Appraisals had not taken place since our last inspection but the registered manager told us appraisals for 2016/2017 would be completed this year. At our last inspection records showed appraisals had been completed for 2015/2016.

The provider's policy detailed that supervisions should be carried out regularly. Out of the five staff files we looked at only one file contained one record of supervision for 2016. The registered manager told us that she was in the process of completing supervisions for all staff and showed us seven completed supervisions for some of the staff that she had completed in October 2016 and that further supervisions was scheduled for this year. The registered manager had carried out a group supervision session for senior carers on December 2016. Topics discussed included medicine issues, completion of MAR's, assisting residents to get up, documentation of challenging behaviour, care plans and nutritional risks. Staff told us they were supported and had no concerns about lack of support from management. One staff member told us, "I am very supported" and another staff member told us, "If you need something, you can ask her [registered

manager]."

Records showed that people had been referred to healthcare professionals such as the GP, medical consultants, district nurse, SALT, community matrons and dietician. Outcomes of the visits were recorded on people's individual's records along with any letters from specialists. Records showed that people were supported to go to hospitals when needed. Staff confirmed people had access to healthcare professionals particularly if they were unwell. They gave us examples of where they were able to identify if people were not well such as a change in personality, lack of eating or just sleeping. Staff told us they would inform the senior carer or the registered manager or in emergency would call emergency services. One person told us "I am taken to my GP and the podiatrist." A second person told us, "When I need to see the GP, they [staff] call him." Another person told us, "They would get the GP if you are not well." A relative told us, "They arrange hospital transport. If [person] is unwell, they get the GP in." During the inspection we observed a number of health professionals visiting the home to review people's health, who were all very complimentary about the home. A social care professional told us, "[Person] has speech problems and a therapist is coming in to support [person]."

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments from people included, "The staff are all very good, very pleasant", "They (staff) are very kind", "I am well looked after", "The staff do ask how I am" and "The staff are always friendly, they never shout." A relative commented, "The staff are very kind to [person]" and another relative commented, "The staff are nice to residents." A community psychiatrist consultant told us, "I have never seen anything other than excellent care or forms of care."

We observed staff were kind, polite and showed patience when engaging with people. The home also had an agreement with the local newsagent to deliver newspapers to the home for people that wanted to read and be kept updated on current news should they want to. We also observed good practise during lunch where residents were able to help other residents with seating and placing cutleries under the supervision of staff.

Staff told us they built positive relationships with people by spending time and talking to them regularly. Staff had a good understanding about the people they cared for. Staff members were able to tell us about people's backgrounds and the care and support they required. They described people's behaviours, likes and dislikes and health conditions.

We conducted a Short Observational Framework (SOFI) after lunchtime. A SOFI is a way of observing people and their interactions when they may not be able to tell us themselves. We saw that people were supervised at all times and if people required support then staff provided support promptly. We observed one person was struggling to get up from their chair and a staff member promptly assisted the person. However, we observed that for long periods staff did not engage with people and people were either staring or watching the television. This was the only instance we saw that staff did not engage with people for a long period as throughout the inspection we observed that staff engaged with people throughout the day asking them how they were and sitting down to talk to people or talking to people as a group. We fed this back to the registered manager and provider who informed the activity co-ordinator would normally engage people with activities but was providing one-to-one activity for a person in their room. The activities co-coordinator confirmed this. The provider told us that they will look into passing responsibility to care staff to engage people in activities during the afternoon should the activity co-ordinator not be available.

Staff told us that they respected people's privacy and dignity which was confirmed by observations during the inspection. We observed that people could freely go into their rooms when they wanted to and close their door should they choose to do so. Staff knocked on doors before entering people's bedrooms. Staff told us that when providing particular support or treatment, it was done in private and we did not observe treatment or specific support being provided in front of people that would had negatively impacted on a person's dignity. A person told us, "When dealing with me they are private with me" and another person told us, "I am given privacy by the carers." A relative told us, "The staff are very careful with [person's] privacy" and another relative told us, "I think the staff do give residents privacy." A staff member told us, "If washing them [people] I would always close the door" and another staff member commented, "When I take them to toilet, I make sure toilet door is shut."

Staff told us that people were encouraged to be as independent as possible. We observed people were able to move around independently and go to the lounge, dining area, toilets, hallways and outside if they wanted to. Staff told us that they encouraged people to be independent but only if they were comfortable. A person told us, "I can manage to move around myself and don't need any help. They [staff] encourage it" and another person told us, "They give me independence, I get out myself." A staff member told us, "We encourage them [people] to wash their faces by themselves."

Records showed that people's religion was recorded. The activities co-ordinator told us that the local priest regularly comes to the home to deliver a sermon to people and photos confirmed this. People were also supported to go to church if they wanted to. A relative told us, "Every Sunday, a church choir comes in and every month a religious minister visits." Another relative commented, "The home has arranged for the Methodist minister to visit."

Staff understood that racism, homophobia, transphobia or ageism were forms of abuse. They told us people should not be discriminated against their race, gender, age and sexuality and all people were treated equally.

Care plans listed how to communicate with people and listed people's ability to communicate. For example, one person's plan listed that staff should hold conversations at a gentle pace and maintain eye contact so the person could understand.

End of life care plans were completed for some of the people and the involvement of their relatives were clearly indicated and people's preferences were recorded.

Good

Is the service responsive?

Our findings

Both people and relatives told us that staff listened to them and people confirmed that they received personalised care that was responsive to their needs. A person told us, "The staff are good, they respond to requests quickly." Another person commented, "When you ask for something, they [staff] give it." A relative told us, "[Person] gets the care [person] needs. They reported something to us and dealt with it." A community psychiatrist told us, "They [staff] make timely referrals if people are unwell."

During our last inspection the home was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found hospital and discharge transfer forms had not been completed for people that went to hospital to ensure continuity of care. In one care plan we found important information had not been included to provide personalised care and support to a person. At this inspection we found that the provider had addressed this issue.

The registered manager told us that all care plans had been reviewed since the last inspection and the format had been changed to make the plans more succinct and personalised. People's care plans were divided into areas which included, eating and drinking, healthcare issues, night care, mental health, moving and handling and continence that listed actions staff should take. Care plans were personalised and person centred to people's needs and preferences. All the care plans we looked at had been completed in full and contained personalised information. These plans provided staff with information so they could respond to people positively and in accordance with their needs. A person told us, "I feel I get everything I need" and a relative commented, "[Person] does get the care [person] needs."

Hospital transfer and discharge forms were being completed that detailed people's conditions and also attached important documents such as DNAR and MAR charts to ensure people received continuity of care.

We checked the care plan for the person where we found important information had not been completed at the last inspection. During this inspection we found that the important information had been included so that there was guidance for staff on how to support the person. The care plan also listed ways to effectively communicate with the person.

Each person had a personal profile, which included personal details such as their next of kin, marital status, GP details and religious background. The care plan also contained what name people preferred to be called by. There was a "My life so far" section, which included details of funeral arrangements and a summary of people's ability to make decisions. There was a 'my care plan summary', which summarised people's needs and preferences throughout the day and how they liked to be supported during the day and their preferences with meals and snacks. A "My life before you knew me section" had been introduced recently and was gradually being added to people's care plans.

Reviews were undertaken regularly with people, which included important details such as people's current circumstances and if there were any issues that needed addressing. There was a review changes section that listed what had been updated in the care plan following the reviews.

There was a daily log sheet and communication book, which recorded key information about people's daily routines such as behaviours and the support provided by staff. We observed that the information was used during staff handovers. We sat in during a staff handover and observed the staff team worked well together and information was shared amongst them effectively and updates were provided on each person's behaviour, health and nutrition that stayed in the home.

People were assessed before being admitted to the home in order to ensure that their needs could be catered for. Admission sheets confirmed that detailed assessments of people's needs were undertaken, including important aspects such as the medicines they were prescribed and their diagnosis. A Do Not Attempt to Resuscitate (DNAR) was in place for some people, and this had been completed in full by a health professional and the originals had been kept in the care plan. This had been placed in front of the care plan for easy access.

Records showed that staff did hourly checks during the day for people that were in their rooms. Half hourly checks were also being completed for people that were in their room and were unwell. Hourly checks were being completed at nights for all people staying at the home to ensure people were safe and comfortable. Staff told us they did room checks to ensure that people were safe and their rooms were in a hygienic state. A person told us, "Yes, I feel safe here; they pop in at night to check on me."

During the last inspection the home was in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found two complaints had not been investigated and people and relatives expressed concerns that their complaints had not been actioned appropriately. At this inspection we found that the provider had addressed this issue.

Since the last inspection, one formal complaint had been received and this had been investigated and resolved appropriately to the satisfaction of the complainant. We saw a letter of apology from the registered manager to the complainant, which listed the actions taken following the complaint. A relative told us, "I did make a complaint months ago and they dealt with it." When we spoke to the staff on how they would manage complaints, they told us that they would record the complaint and inform the manager. People and relatives told us that they had no complaints about the home and knew who to complain to if required. A person told us, "I've no reason for complaint." A social care professional told us, "[Person] did not have any concerns" when asked if the person they had visited had any concerns.

Records showed that the home had received compliments from relatives. Comments included, "Thanks for all your love and care for [person] while [person] was at Parkside and for your kindness to me", "Thanks to all the managers and staff for help and assistance given to [person] during their short stay at home" and "Thank you so much for caring for [person]. [Person] was very comfortable and enjoyed being at Parkside. [Person] was the happiest that I have seen for a long time. You all do such a marvellous job."

There was a programme of weekly activities. Observations confirmed people participated in activities such as arts, quizzes and musical bingo. There were pictures and painting around the house that evidenced people took part in creative artwork and carried out activities. The home was decorated for Christmas and staff and people told us that they had celebrated Christmas. We observed the activities coordinator going to people's room to deliver individual activities and exercise. The activities coordinator told us that she would do individual activities with people who did not like to participate in group activities. We also observed that a hairdresser came and people were able to get their hair done. We saw records that people were able to go outside. Records showed that people had gone to see the pantomime and had attended a local school where children sang Christmas carols to them. The activity coordinator told us that children from the local school came to the home to meet and sing to people. One person told us, "There is enough to keep me

entertained. We have music, bingo and play dominos" and another person commented, "There is enough entertainment for me here, we get out shopping sometimes." A person also told us, "I do take part in some activities; there is enough to interest me". A relative told us, "[Person] enjoys the activities." A staff member told us, "The activities here are very good. She [activities co-ordinator] takes them out, takes them to theatre and shopping."

Requires Improvement

Is the service well-led?

Our findings

People told us that they liked staying at the home. One person told us, "I'm very happy here." A relative told us, "I'm quite happy with things here." Staff told us the culture within the home was open, caring, transparent and they enjoyed working at the home. Staff told us that improvements had been made since our last inspection and also because of the systems put in place by the registered manager. One staff member told us, "I like it here, I like working with the residents." Another staff member told us, "Before it was bad but now it is much better here." A relative told us, "The best thing here is the caring ethos."

People and relatives spoke positively about the management of the home and two relatives told us that things had improved since the last inspection. One person commented, "The manager is very nice, she makes herself available. She knows what's going on." Another person told us, "I like the manager, she says hello." A relative told us, "The manager is excellent, she is a listener. She has turned this place round." Another relative told us, "You can approach the manager very easily. Things have got so much better." We observed the manager assisted people when asked and engaged with people in a friendly and caring manner.

Health and social care professionals we spoke to were very complimentary about the registered manager. The community matron from the CHAT team told us, "She understands systems and processes" and "On the whole, [registered manager] has made some in-roads." A social care professional told us, "She seems pleasant and polite." A community psychiatrist consultant told us, "She is good, knowledgeable and knows people and staff well."

Staff told us they felt well supported by management. One staff member told us, "She [registered manager] is lovely. She can do everything, she is very good." and another staff commented, "She is very good." The interaction between staff and the registered manager was professional and respectful.

During the last inspection the home was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. We found quality assurance systems were not in place. There were no internal audits, results of surveys had not been analysed, an action plan had not been sent to address our findings of our inspection on January 2016 and there was lack of managerial oversight on staffing and training.

During this inspection we saw that improvements had been made. The previous manager had left and in place was the manager who used to manage the home and had returned. Quality assurance systems were in place. Weekly internal audits were being carried out on medicines that identified errors and immediate action was taken, this was also communicated to staff in meetings. The registered manager also carried out daily audits, which included checks on people, fire safety, supervising meal times and observing medicine rounds. Weekly health and safety checks were carried out to ensure people were safe from potential hazards. Checks also included checking people's rooms, clinical waste, the kitchen, the laundry room and the staircase. However, the audits had not identified the concerns we found with risk assessments. The registered manager told us the risk assessments would be reviewed and amended to make the assessments

specific to people's circumstances.

The service had a quality monitoring system which included questionnaires for people and relatives. We saw the results of the questionnaires for October 2016, which was generally positive and covered important aspects in service, staff, decision-making, personal care, staffing and person centred care. Records showed that results of the surveys were analysed and also used to make improvements. Some concerns were raised with meal times and records showed that this was discussed with people in residents meetings and a new menu was subsequently created. People and relatives we spoke to did not raise concerns regarding food. A staff member told us, "Food has got a lot better." This meant that quality monitoring systems were being used to make continuous improvements.

During the last inspection we were informed and we observed the previous manager combined her managerial duties with personal care and roles and responsibilities were not clear. The provider informed us after the inspection that the manager would concentrate on managerial duties and the manager's role in providing personal care would be limited. During this inspection the registered manager told us she was able to concentrate on managerial duties and only supported people when required or in emergencies. Senior carers were in place and staff were aware of their roles and responsibilities. Staff told us that there was an organised management structure and they knew what to do when starting work.

During our last inspection the home was in breach of Regulation 18 the Care Quality Commission (Registration) Regulations 2009. We found that no statutory notifications had been made to CQC in respect of outcomes to DoLS applications. After the inspection the registered manager sent us notifications of outcomes of DoLS applications that had been made.

A residents meeting took place on October 2016 and records showed residents were able to discuss and provide their thoughts on activities and food. Staff meetings were held on October 2016. Topics included complaints, medicines, teamwork, infection control and updates on people. Minutes were available from both meetings.

During the last inspection we found eight breaches that required by law a written report of the action that the provider was going to take to meet the Health and Social Care Act 2008, associated Regulations and any other legislation we have identified the service was in breach of. The provider sent us an action plan detailing how they would address each breach identified at the last inspection. During this inspection we found one breach of the Health and Social Care Act 2008. Although some concerns remains with risk assessments the provider and registered manager had made a number of improvements and people were not at immediate risk of harm as we identified at the last inspection. The home will need to make improvements with risk assessments and demonstrate that the improvements that had already been made had been fully embedded and sustained. We will check this during our next planned comprehensive inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks to service users to ensure people received specific support and care. Regulation 12(2)(b).