Parkcare Homes (No.2) Limited

Manor Field

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 4 and 5 October 2017. This residential care home is registered to provide accommodation and personal care for up to six adults. At the time of our inspection there were three people living at the home.

There was no 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.

Improvements were required to ensure that staff had a good understanding of their safeguarding responsibilities and that any concerns were reported and investigated promptly. Improvements were also required to ensure that all required notifications were submitted to the Care Quality Commission in a timely way.

Improvements were required to the quality assurance procedures within the home. The quality assurance systems that were in place were not robust enough to identify or act on the failings within the home. People's care plan records were incomplete and inaccurate and documentation relating to people's care was not always easily accessible.

Accidents and incidents were not always recorded appropriately. As a result there had been an ineffective system of reviewing incidents, identifying trends and taking action to prevent similar occurrences. People's risk assessments were not regularly reviewed or updated and it was unclear which guidance staff should follow to help manage people's risks.

Improvements were required to ensure staff had the training they required before people moved into the home, and that they had regular supervision about their performance to identify any training needs. Improvements were also required to ensure that the home monitored people's Deprivation of Liberty Safeguards (DoLS) applications and that staff understood who this applied to.

People were supported to eat the foods they liked however improvements were required to ensure that people received consistent support to have a balanced and nutritious diet. People's healthcare needs were met however improvements were required to ensure these were monitored and kept under review.

Further consideration and improvements were required to the pre-admission assessment procedures to ensure that staff were able to meet people's needs when they moved into the home. Management needed to give consideration to staffing skills and training needs, the location of each person's bedroom, and how they would integrate with other people already living at the home.

People's care plans were confusing, difficult to follow and required attention to ensure they were accurate

and complete. Care plans had missing information, and duplicated information. There was also conflicting information and people's care plans did not always correlate with the care they received.

There were no systems in place to ask people, their relatives, staff or any professional involved with the service for their feedback. The quality assurance systems in place were not effective at ensuring timely action was taken to improve the home.

People received their medicines safely however improvements were required to ensure that all medicines were stored in accordance with best practice. Staffing levels were sufficient to support people to receive the care they required, and staff were recruited in a safe way.

People told us they enjoyed living at the home. They had developed good relationships with staff and were comfortable spending time with them. Staff had a good knowledge about the people they supported and encouraged them to express their own views and make their own decisions.

Protecting people's privacy and dignity were key values within the home and people's individual preferences were respected. People were supported to maintain relationships that were important to them, for example, with family or friends.

We identified that the provider was in breach of two of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The service was not always safe.

Improvements were required to ensure that safeguarding procedures were fully understood and acted on.

Improvements were required to ensure people had adequate risk assessments which reduced the risks to people.

Improvements were required to ensure that accidents and incidents were recorded and reviewed.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were required to ensure staff had adequate training, supervision and feedback.

Improvements were required to ensure that Deprivation of Liberty Safeguards (DoLS) applications were monitored and fully understood.

Improvements were required to ensure that people received consistent support with their nutrition.

Is the service caring?

Good

The service was caring.

People and staff developed positive relationships together and people were comfortable spending time with the staff.

People were encouraged to make their own decisions and choices.

People received personalised care and staff were encouraging and attentive.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required to the pre-admission procedures.

Improvements were required to ensure people had accurate and complete care plans in place.

Improvements were required to support people with consistent care to achieve their goals.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were ineffective quality assurance systems in place which failed to identify poor practice and to make the required improvements in a timely manner.

People's records required improving to clearly and succinctly identify the care people received and required.

Appropriate notifications had not always been submitted promptly to the Care Quality Commission as required.

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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 and 5 October and was unannounced. The inspection was completed by one inspector.

Before the inspection, the provider 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. The provider returned the PIR and we took this into account when we made judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification provides information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home, and Healthwatch England, the national consumer champion in health and social care to identify if they had any information which may support our inspection.

During our inspection we spoke with three people who used the service, two relatives, six members of care staff, the acting manager and the registered provider. We also reviewed information we had received from healthcare providers that supported people within the home.

We looked at care plan documentation relating to three people, and three staff files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

Improvements were required to ensure people were protected from harm. People and their relatives felt they were safe at the home however staff had a limited knowledge about how to report matters of concern. Staff did not understand how they could report safeguarding concerns without involving their manager and this meant that when there had been concerns about people's care there had been a delay in reporting concerns promptly.

Staff were unaware how to contact the local authority or the Care Quality Commission to report their concerns and staff were unfamiliar with the provider's whistleblowing procedures. We spoke with the acting manager and provider about this and they told us that the information was available on the staff intranet and posters would be displayed in a prominent place. However, further support would be required to ensure staff had a good understanding of the relevant contact details and that they felt confident to report their concerns.

We asked to see the investigations of previous safeguarding concerns and these could not be found. The acting manager was unclear if the previous manager had completed full investigations and no relevant paperwork was located during the inspection. Safeguarding notifications were not always submitted in a timely way. This meant we could not be sure that safeguarding incidents at the home had been properly addressed.

These failings were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Accidents and incidents were not always documented. Staff told us they had not been aware that they should complete an incident form after each incident when a person displays behaviour that may harm themselves or others. They told us that after their recent training they were committed to making sure they followed this procedure. As a result of staff not previously completing incident forms there had been an ineffective system of reviewing incidents, identifying trends and triggers and taking action to prevent similar occurrences.

People were not always protected from the risks that had been identified as relevant to each person. People had risk assessments in place which identified when they could potentially be at risk of harm however they were not regularly reviewed or updated after an incident had occurred. Risk assessments were duplicated and it was unclear which guidance staff should follow. The provider had recognised that the risk assessments required improvements however this had not been completed in a timely way.

People received their medicines in a safe way however improvements were required to ensure medicines were stored safely and that people always received their medicines in a consistent way. One person told us, "They [the staff] bring me medicines each day. They don't forget." One relative said, "They're very good with medicines and as far as I know [name] gets them when they need them."

There had been an inconsistent approach to the storage of people's medicines. Controlled drugs had not always been stored in accordance with best practice, i.e. storing them in a separate fixed medicine cabinet. Following the inspection, the provider immediately ordered a controlled drugs cabinet to securely store the required medicines.

There were sufficient numbers of staff to keep people safe and allow them to have some choice over how they spent their time. However we found there were occasions that people had requested to complete an activity out of the home that required transport and this had been delayed due to the unavailability of staff that were able to drive. Staff told us that this had not caused a big issue for people however improvements were required to ensure that people's wishes were respected. After the inspection an additional member of care staff was recruited to assist with the driving requirements of the people that used the service.

People were protected against the risks associated with the appointment of new staff. One member of staff told us they had to wait to start work. They said, "I had to wait for my checks to come back before I could start shadowing." There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate checks and references in place and satisfactory Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out criminal record and barring checks on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

Improvements were required to ensure staff had the skills and competencies to support the people that lived at the home by having training at the right times. Staff told us they did not always feel prepared or equipped to support people, particularly when people displayed behaviour which may harm themselves or other people. One member of staff told us, "Sometimes our training is too late and we aren't prepared before people move in. It can make some situations really hard." The management team acknowledged that there had been some delays in providing staff with specific training but that this outstanding training had now been arranged and further efforts were being made to recruit an additional member of training staff to prevent this issue reoccurring.

We reviewed the training program and saw that training was varied to meet a range of needs but the monitoring of this was not always effective. For example, staff had an induction which provided them with an introduction into care and supported the Care Certificate. However, when systems showed that staff training was about to expire, or that staff had not completed the required training, action wasn't always taken to ensure staff had their training refreshed in a timely way.

Staff were not always appropriately supervised or given regular feedback about their performance. Staff told us that they felt they could approach the acting manager with any concerns or ideas about how to improve the service, however in the past this option had not always been available to them. We saw that staff had received supervision in the past but not on a regular basis and some staff had not had any supervision for almost four months. Staff annual appraisals had not yet been completed as staff had not been in the service for more than a year.

People using a service can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA and we saw that they were not always doing so. The 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.

We found that when it had been identified that people did not have the capacity to make their own decisions the management team followed the principles and if necessary, sought applications with the Deprivation of Liberty Safeguards (DoLS) team appropriately. However, the management team were not able to confirm if people living at the home had DoLS applications approved and authorised. The staff had an understanding of the DoLS process and what this meant for the people living at the service, however further clarification was required to confirm who this applied to.

We saw that when people lacked the capacity to make their own decisions, a mental capacity assessment had been made. Improvements were required to ensure that the assessments, and any subsequent decisions, were specific to the area the person needed support with, and they were clearly documented.

Staff worked well with people, ensuring they consented to the care they provided and encouraged people to make their own decisions.

People were supported to eat the foods and drinks they enjoyed however improvements were required to ensure that people got consistent support to have a balanced and nutritious diet. Each person's support at mealtimes was individualised to meet their needs but there was little guidance for staff about how to do this in a consistent way. For example, one person ate four main meals a day however there was no guidance about portion size, or any approaches to support the person to try new foods. One member of staff told us that they would sometimes add vegetables into the person's preferred meal options but this was not consistent with all staff.

People were supported to have their healthcare needs met however improvements were required to ensure these were kept under regular review. People's health action plans were incomplete and as a result staff did not have easy access to confirm if and when people's last regular healthcare checks had been made.

Good

Is the service caring?

Our findings

People told us that the staff treated them well and they appeared relaxed and comfortable in the company of staff. One person said, "They're caring [and] supportive. Everyone's perfect. Everyone tells you the truth. I'd give them five stars!" One person's relative said, "It's the best home [name's] ever had. It's brilliant."

Staff demonstrated a good knowledge and understanding of the people they cared for. Staff understood people's needs, and could interpret people's behaviour when they were unable to communicate this themselves. For example, one person would make loud sounds when they were happy and staff celebrated this with them. Staff had developed trusting relationships with people and understood the need to respect people's wishes and personal beliefs.

People were encouraged to express their views and to make their own daily choices. One person told us that the staff listened to them and they were able to make their own decisions about what they did and when. Staff told us they were there to support and encourage people but ultimately each person was responsible for making their own decisions. This included decisions about independent living skills and the time of day they to get up. Staff were respectful, and offered gentle encouragement where appropriate to assist people to make their own decisions.

Respecting people's privacy and dignity were key values within the home and staff practice showed consistency in upholding these values. On a practical level if people were unable to take action to protect their own privacy, measures were in place to support them. For example, nobody outside of the building could see into people's bedrooms and staff recognised when people may need additional privacy or space if they were displaying behaviour that may harm other people. Staff ensured that other people within the service were protected and people were treated with respect.

We observed the staff provide personalised care which supported people's individual requirements. Staff were encouraging and attentive. They consistently praised people when they made positive choices or coped well with new experiences. For example, one person liked a specific routine whilst they went shopping. Staff understood this routine and had developed positive relationships and an understanding from the staff that worked at the shop. When this routine had to be unexpectedly changed, the person was given reassurance and praise, and the person was made to feel proud of their achievement.

People's friends and relatives were able to visit people at their home if they wished, and the staff supported people to visit family at their own addresses, or at mutually convenient locations. One person's relative told us that they lived some distance from the home but the staff regularly supported them to see their loved one by driving them to an agreed location. We also saw that when one person's relative had become too unwell to have them come to their house to stay for a visit, the staff had arranged for the person's family to come and have dinner at the home. Staff supported and encouraged people to maintain relationships with the people they cared about.

People within the home had access to an advocate and the management team were working to establish

links with an independent advocacy service to ensure this was available for people that wished to use it.

Requires Improvement

Is the service responsive?

Our findings

Improvements were required to the pre-assessment procedures that were in place to ensure that all members of staff had the appropriate knowledge and skills to meet people's specific needs before they arrived. For example, the service had accepted people into the home with varying backgrounds without ensuring staff had the abilities to provide people with the support they required. There had not always been full consideration to the best location for each person within the home, and how everyone would integrate together. This had resulted in some people being unable to stay at the home for as long as had originally been planned.

People's care plans required further attention. Each person had a care plan which identified their history and how their needs were to be met; however the plans were confusing and difficult to follow. Staff told us they did not use the care plans and felt they needed training to understand how they could be used better, to refer to them and keep them up to date. Some people's care plans had duplicate copies of the same information and other pieces of information were missing or had not been updated. For example, there was inaccurate information about how one person preferred to spend their time and on what days of the week they were at home. Another person's care plan stated that staff should encourage them to follow a calorie controlled diet however there was no further guidance for staff about this, and staff told us they were unable to follow this in practice.

Each person was supported to identify their short, medium and long term goals whilst living at the home. We saw that one person had these recorded in their care plan; however there was no strategy to achieve these goals. During discussions with staff, it was clear that the staff were adapting their own approach and this had led to inconsistent support. There had been no reviews of each person's goals, and no discussions as a staff group about the different approaches that had been attempted, and what the outcomes of these were. There had been no agreed method of how each person should be best supported to achieve them and as a result there was no evidence to show if people had made any progress to achieve their goals.

People showed positive progress from living at the home. For example, one person's relative told us that since moving to Manor Field their relative's well-being had improved and they had been supported to gain more independence. Staff were proud of the achievements people had made. They told us about one person whose social skills had improved and who had progressed to helping with some cleaning tasks at the service. The person told us they felt good and they were happy at the home.

People were supported to participate in the activities they enjoyed. Staff had a good understanding of how people liked to spend their time, and the routines that they appreciated. People were able to choose whether they wished to stay at home or go out, and staff supported them to complete the activities that enjoyed. One person particularly enjoyed watching trains and they were supported to watch them on the DVDs and by seeing them in real life. Another person had been supported to do voluntary work at a local business and was praised and encouraged for the new skills and independence this had given them. A further person chose to stay at home with the staff and they treated the person to a beauty pamper session which they clearly enjoyed.

A complaints procedure was in place which explained what people or their relatives could do if they were unhappy about any aspect of the home. One person using the service had raised concerns about the service and this was investigated thoroughly. We also saw that a healthcare professional had expressed concerns over the care of one person and the provider had taken swift action to resolve those concerns.

Requires Improvement

Is the service well-led?

Our findings

Procedures to review the quality of the service were insufficient and required improvement. The provider employed a quality improvement team to complete approximately quarterly auditing of the home; however the timing and depth of these had failed to identify or act on the shortfalls in evidence during this inspection visit. We found that the quality assurance systems in place were not robust and did not examine many aspects relating to the running of a care home.

The quality assurance systems failed to review important aspects of people's care. For example, there was a lack of regular auditing of people's care plans to ensure they were current and accurate. The auditing systems did not recognise that the care plans did not give sufficient guidance for care staff to provide consistent and appropriate care, or that they correlated with the care that people required.

The quality assurance systems failed to ensure there were adequate systems to monitor the quality and safety of the service, and that the service was complying with the regulations. For example, there were no checks to ensure that DoLS applications were appropriately completed, that incidents and accidents were recorded when required and that prompt action was taken when learning had been identified.

Improvements were required to ensuring timely action was taken for outstanding actions. For example, the provider had recognised on 23 August 2017 that people's risk assessments needed reviewing and updating however this had not been completed by the time of this inspection visit. The provider had also recognised that a DoLS folder and tracker was required to ensure that the management team were aware of people's DoLS status. This action was also still outstanding at the time of this inspection visit.

Improvements were required to ensure that people and their relatives, staff and other people involved with the service were encouraged and supported to provide their feedback about the care that was received. There were no surveys or questionnaires sent to any of the parties involved and therefore the opportunity for the provider to reflect on people's feedback was missed.

These failings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was no registered manager in post. The provider had made interim arrangements to support the management of the service and had taken steps to begin the process of recruiting for a new registered manager.

Improvements were required to the understanding of the notifications required by the Care Quality Commission, and the promptness required for these. The provider had not always submitted the notifications required in a prompt manner.

The culture within the service was focussed on ensuring people received the care and support they required. Staff were committed to this and further guidance and support was required to ensure that all care was

consistent and reviewed on a regular basis to consider what was working and what required changing.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes did not operate effectively to prevent abuse of service users and to investigate immediately upon becoming aware of any abuse or allegation of abuse. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were ineffective at identifying poor practice and no systems were in place to request feedback on the quality of the service. Regulation 17 (1) (2) a, b & e