New Park House Limited

New Park House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 December 2016 and was unannounced. At our previous inspection in June 2016 we had judged the service as Inadequate and placed it into special measures as we had found the service was not safe, effective or well led. At this inspection we found that although some improvements had been made further improvements were required and there were continuing breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service will remain in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months.

New Park House provides nursing and personal care to up to 95 older people. At the time of this inspection 76 people were using the service.

There was a new manager in post who was yet to register with us. 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.

People's medicines were not managed safely. People did not always have their medicines at the prescribed times. Medicine records did not confirm that people had topical creams applied as prescribed. Some cream had run out of stock and some medicine was out of date and ineffective.

Risks of harm to people were not always minimised through the effective use of risk assessments. Staff required training in some areas to be able to care for people safely. People's care records were not always up to date with information to support staff to care for people.

People were not always safeguarded from abuse or the risk of abuse as unexplained injuries were not always reported and investigated.

There were sufficient number of staff deployed throughout the service. They had been recruited using safe recruitment procedures to ensure they were safe to work with people.

The provider was following the principles of the MCA 2005 to ensure that people consented to or were supported to consent to their care, treatment and support.

People's nutritional needs were being met however some people would have benefited from encouragement and support to eat. People had a choice of meals and specialist diets were catered for.

Staff were supported and received training to fulfil their role. However some staff would have benefited from training in how to support people with challenging behaviours.

People's health care needs were met. When people became unwell or their needs changed health care support was gained. People attended health appointments in the community and from visiting health care professionals.

People were offered opportunities to engage in hobbies and activities of their choice. There was a range of entertainment within the service dependent on people's individual needs. The provider had a complaints procedure and people felt they were able to complain if they needed to.

People told us they were treated with dignity and respect, however we observed that people's right to privacy was not always up held.

People told us they respected the management and that they were able to have a say in how the service was run. Improvements had been made since our last inspection however some of the systems the provider had in place to monitor and improve the service were ineffective.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

People's medicines were not always stored or administered safely.

Risks of harm were not always assessed and minimised through the effective use of risk assessments.

People were not always safeguarded from abuse as incidents of potential abuse were not always investigated.

There were sufficient numbers of staff who had been recruited using safe recruitment procedures.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The principles of the MCA were being followed as people were consenting to their care and treatment or being supported to make decisions in their best interests.

Some people would have benefited from more support to eat and drink.

People received health care support when they were unwell or their health needs changed.

Staff felt supported however some staff required training and supervision to be fully effective in their roles.

Is the service caring?

Requires Improvement

The service was not consistently caring

People's right to privacy was not always upheld.

Most people felt they were treated with dignity and respect.

People were able to maintain their friendships and relationships.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care records did not always reflect their current care needs and some staff did not know people's needs.

People were encouraged to be involved in hobbies and activities of their choice.

There was a complaints procedure and people felt able to complain. Complaints were managed as per the provider's policy.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems the provider had in place to monitor the quality of the service were not always effective.

People and the staff respected the management and felt that the service was well led.

Some improvements had been made since our previous inspection.

New 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 19 December 2016 and was unannounced. It was undertaken by three 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.

We reviewed the information we held on the service. We looked at notifications sent to us by the manager and used the action plan they had sent us following our previous inspection to inform the inspection. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any incidences which put people at risk of harm. We refer to these as notifications.

We spoke with 10 people who used the service and four relatives. We spoke with eight care staff, two nurses, the manager and area manager. Our feedback involved the nominated individual and directors of the service. Some people were unable to talk to us due to their communication needs so we observed their care. We used our short observational framework for inspection (SOFI) tool to help us see what people's experiences were like. The SOFI tool allowed us to spend time watching what was going on in a service and helped us to record how people spent their time and whether they had positive experiences. This included looking at the support that was given to them by the staff.

We looked at the care records for 13 people who used the service. We looked at staff rotas and three staff recruitment files. We looked at the way in which people's medicines were managed. We also looked at people's daily care records and records of their medication. We looked at the systems the provider had in place to monitor the quality of the service. We did this to see if they were effective.

Inadequate

Is the service safe?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 12 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014 as care and treatment was not always safe. At this inspection we still had concerns about people not always receiving safe care and treatment.

We found that people's medicines were not managed and administered safely. We found eye drops that were out of date and being administered to people. This meant that the medicine may not be effective. We saw that one person had complained that they had not had their prescribed pain relief offered to them for two nights. We were told that an agency nurse had been on duty on the two nights in question, however the person's records clearly recorded that the person took these medicines regularly. We saw that people did not always have their medicines at the prescribed times. For example one person had been prescribed time critical medicines for the treatment of a specific condition. If people with this condition don't get their medication on time, their ability to manage their symptoms may be lost. We saw they were not having their medicines at the prescribed times. We discussed this with the management who were not aware that these people were not having their medicines at the prescribed times.

Some people were prescribed 'as required' (PRN) medicines such as pain relief or anxiety medicines. There were no instructions to staff as to when these people may require these medicines. Some people due to their cognitive impairment may not have been able to inform the staff when they required the medicines. We saw gaps in signatures on topical medication administration records (TMAR)'s. It was unclear as to whether people had had their topical cream applied and this left them at increased risk of sore skin.

We found that the medicine trolley in the nursing unit did not lock. This meant that if only one nurse was administering the medicines they may have to leave the unlocked trolley unsupervised. A nurse told us that it had been reported several weeks before and the manager told us that they had been trying to find a solution to the issue.

Risks of harm to people were not always assessed or minimised safely. We saw one person had been assessed as requiring regular checks when they were in bed due to being at risk of falling. We saw these checks were not being completed as they should be and this put the person at risk of harm. We were informed the following day that this person had fallen and had received a serious injury. This meant that this person had come to harm as their risk assessment had not been followed.

We observed one person being supported to stand with the use of a stand aid in an unsafe manner. We saw that they had a handling belt around the chest area, when it should be around the waist. We saw this person was supported to stand with the belt around the chest which could have caused discomfort. This person was not being supported to move safely.

One person had an infection which required nursing in a specific way. People with this condition should be barrier nursed. Barrier nursing is a set of stringent infection control techniques used in nursing. The aim of barrier nursing is to protect medical staff against infection by patients, particularly those with highly

infectious diseases and prevent the spread of the infection.The nursing staff caring for the person were unaware that this person had this condition and there were no precautions in place for staff to prevent the spread. This put the person and other people at risk of infection.

Several people required their food and fluid intake monitoring as they were at risk of weight loss or dehydration. We saw these records were not always being completed and this put these people at risk of not eating and drinking sufficient amounts. Other people required regular repositioning as they were at risk of sore skin if they sat or lay in the same position for too long. We saw that people's repositioning records were not always completed. This meant that people may not have been repositioned as they should be and put them at risk of sore skin.

Some people experienced periods of anxiety which led to them becoming aggressive towards other people and staff. We saw records and staff confirmed that they were regularly receiving injuries whilst supporting one person. Staff told us that they had not received any training in how to support this person or other people at these times. The risk assessments in place lacked clear detail as to how to support people when they were anxious. They were generic and not specific to the individual people. This put the person,other people and the staff at risk of harm.

These issues constitute a continuing breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although staff we spoke with told us they knew what to do if they suspected someone had been abused, we saw records that showed that several people who used the service had received bruising and injuries which were unexplained. The manager had not been made aware of the injuries as they had been recorded in people's daily notes and not passed on. These injuries had not been investigated and had not been reported to the local authority for further investigation. This meant that people were at risk of abuse as injuries were not being investigated and action being taken to minimise the risk of further injuries.

This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection the provider was in breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There had been insufficient staff to safely meet the needs of people who used the service. At this inspection we found that improvements had been made and they were no longer in breach of this Regulation.

Staffing levels throughout the service had been increased to meet people's needs. The area manager told us that they were using a dependency tool to ensure that there were enough staff available at all times. There had been several new nurses and care staff recruited since our last inspection. One person who used the service told "I can't complain. They look after me, check on me, even the night staff check me every two hours. They usually answer the buzzer between three to five minutes. I think there are enough staff but I know they get the agency staff in when they are short. I am very satisfied". A relative told us: "More staff have been brought in and they are trying to increase the staffing levels, no dates given but on-going".

Safe recruitment procedures were followed to ensure that new prospective staff were checked for their fitness to work with people. References and Disclosure and Barring (DBS) checks were completed to ensure that the prospective staff was of good character. The DBS is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection the provider was in breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was not ensuring that the principles of the Mental Capacity Act 2005 (MCA) were being followed. 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.

Previously we had found that that some people had a Do Not Attempt Resuscitation (DNAR) record on their care file which had been put in place at a time when they had been unwell and unable to consent. These people had recovered and had the capacity to consent to agree to a DNAR if they so wished. The DNAR's had remained in place at the front of the people's care files without having been reviewed and this left people at risk of not having any lifesaving care at a time they may have needed it. At this inspection we found that the management and staff were in the process of reviewing people's DNAR with them, their GP or legal representative and this was on-going.

At our previous inspection we had found that several people had been referred to the local authority for a Deprivation of Liberty Safeguards assessment (DoLS). The Deprivation of Liberty Safeguards (DoLS) is part of the Mental Capacity Act 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. However the management and staff could not tell us who was subject to an authorised Deprivation of Liberty and who was not. At this inspection we found that improvements had been made and the manager had implemented a DoLS tracker which recorded who was subject to restrictions and who had been referred to the local authority and was waiting for an authorisation.

We saw when a person lacked mental capacity and was refusing to take their prescribed medicines or refusing personal care, meetings were held with the person's representatives and other social care and health agencies to make a decision in the person's best interest. These decisions were clearly documented within the person's care records. This meant that people were being supported to consent to their care and support to maintain their health and wellbeing.

At our previous inspection we had found that the provider was in breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's nutritional needs were not always being met. Several people had lost weight and no action had been taken. At this inspection we found that some improvements had been made and the provider was no longer in breach of this Regulation, however further improvements were required. We found that when people lost weight they were referred for advice and support from their GP or dietician. Several people were on special diets and were prescribed food supplements and we saw people were given these as required. One person told us: "I have a problem with swallowing so my food is pureed. Today they have given me extra food; a banana and a milky way and a food supplement drink. I only like neutral flavour and I always get that one." People were offered a choice of

foods throughout the day and snacks. However, at mealtimes, although some people received support we saw several people who would have benefited from more staff support and encouragement to eat. Several people sat with their meals in front of them and did not eat or ate very little. Some food had gone cold and was unappetising and staff did not interact and encourage people to eat. We saw one person's meal was taken away after a period of time uneaten without the staff member asking or encouraging the person to eat a little more. We saw some people who may have benefited from plate guards or customised cutlery to help them to eat independently. This lack of support and specialised items may have put people at risk of weight loss.

When people became unwell or their health needs changed, health care support was gained from other agencies. A GP visited the service on a weekly basis to discuss any concerns that had not required immediate attention. People received support from district nurses, speech and language therapists and consultants when needed. One person told us; "The optician visits here, I have had new glasses. The chiropodist also visits regularly".

At our previous inspection untrained staff had been supporting people with their nutrition through a feeding tube, this is called 'PEG' feeding. Since the inspection staff had received training in PEG feeding and were now competent to support people with this process. Staff told us they had received support and supervision from a senior member of staff and that they received on-going training. One staff member told us: "We do get training. I had an induction and did some shadowing before I supported anyone on my own". Another staff member told us: "I've done paper based training and we get face to face training for manual handling like using the hoist and the stand aids". However staff we spoke with told us they had not had any training in supporting people with challenging behaviour and they were being injured. We also observed poor moving and handling with the incorrect use of a handling belt. This showed that not all staff were competent and effective in their roles due to a lack of supervision and training.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we had found the provider was in breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated with dignity and respect. At this inspection we found that some improvements had been made and they were no longer in breach of this Regulation, however further improvements were required.

We saw people's care records were left outside their bedrooms throughout the morning. These records held personal information within them and could have been easily accessed by anyone visiting the service. We also saw that staff had left continence aids outside people's room in preparation for when they were going to be entering their rooms to support them with personal care. This did not respect people's right to privacy and allowed visitors to the service to be made aware of the private needs of people.

Most people we spoke with told us that staff were kind and that they treated them with respect. One person told us: "The staff are lovely here, they do their best for you". However another person told us: "Sometimes I ask for my frame and they don't bring it and I have to sit and wait and some staff will say I can't do everyone at once so you'll have to wait".

Staff we spoke with demonstrated kindness when talking about people they cared for. One staff member told us: "The best thing is, the residents, they're all different and it's nice to think we're helping them, it's nice coming to work". Another staff member told us: "I love getting to know the residents; it's not just a job to me". We saw a member of the management team taking vases of flowers into people's rooms. One person told us: "We often get flowers".

Most of the interactions we observed were positive with staff and people laughing together and having respectful two way conversations. However we did observe a member of staff turning the TV off in the lounge without asking anyone if they were watching it. We also saw a member of staff push someone in their wheelchair into the lounge area and then just walk away with no explanation of what they were doing or conversation between them.

Some people gave us examples of how their choices were respected. One person told us: "I'm quite happy here and well looked after. My visitors can come anytime. I prefer to stay in my room and read". Another person told us: "I am happy with all the care received here; I go to bed at 7.00pm because I want to and I get up at 7.00am from my choice. I feel safe here".

Relatives and visitors could visit at any time and there were regular meetings for people to contribute in how the service was run. A relative told us: "I attended a relatives meeting last Saturday afternoon. At the meeting the manager asked for any concerns. The manager informed all at the meeting about proposed changes. They're trying to increase staff levels". People were encouraged to maintain friendships. One person told us: "I sometimes visit friends in the other unit, my friend is there. My family live abroad but they ring me sometimes and speak to them". We saw another person supported by staff to take a phone call from a friend and they were happy to be able to speak to them.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we found that the provider was in breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always receiving care that met their individual needs. At this inspection we found that some improvements had been made and they were no longer in breach of this Regulation, however further improvement was required.

We found that some of the information in people's care plans did not reflect people's current needs. Plans for supporting people when they were anxious were generic and not specific to the person. One staff member told us: "[Person's name] is better when left to get up at their own speed, they are in a better frame of mind and less aggressive". This information was not documented in the person's care plan and some staff were not aware of this and we saw records that showed that this person was being encouraged to get up. Not all staff knew people's needs, for example some staff did not know that one person had an infection which required particular attention. The area manager told us that they were in the process of updating people's care plans.

People were encouraged to engage in hobbies and activities of their choice. There was a planned schedule of activities which included external entertainment coming into the service. On the day of the inspection a group of students accompanied by their tutors were in the service singing Christmas carols and playing instruments. They visited all parts of the service to ensure everyone who wished to were able to participate. A brass band was planned for the evening entertainment. A relative told us: "There is brilliant entertainment here, I take my relative to join in and he enjoys it".

We found that people who had previously been cared for in bed with no explanation as to why they were in bed were now offered the opportunity to sit in the communal areas. Specialist chairs had been purchased to enable people to sit comfortably in the lounge area. We saw several people in the lounge area of the nursing unit watching the TV and enjoying the entertainment of Christmas singers.

People's rooms were personalised and we saw that the unit for people living with dementia was being improved to support people to orientate to time and place. There were photos and memorabilia outside people's room to help them find their own room. There was a large white board with the day, date and the weather and season. A nostalgia room had been created with posters and items relating to wartime. There were items such as coronation mugs, a desk with old typewriter and an old style vacuum cleaner and a wireless set. A member of staff told us that several people enjoyed using this room.

There was a complaints procedure and this was visible in the foyer of the service. People we spoke with knew how to make a complaint if they needed to. A relative told us: "I have no complaints. I am not aware of the complaints procedure but would find out if I needed to. I am very happy, in fact since moving here my relative has looked better than in years". The manager showed us that they had received complaints and they were dealing with them as per policy.

Requires Improvement

Is the service well-led?

Our findings

There was a new manager in post who was in the process of registering with us. They had worked at the service for some time and knew people well. We found that the management and provider had been responsive and worked towards making the required improvements since our last inspection, however further improvements were required.

At our previous inspection we had found the provider in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems they had in place to monitor and improve the service were not effective. Previously people's care records were not up to date and did not contain current information on people's needs. This meant that staff did not always have access to the correct information within the care records to be able to care for people safely. This had put people who used the service at risk of poor care due to ineffective records.

At this inspection we found that some people's records still did not contain effective and up to date information. We found that records in relation to people receiving care they had been assessed as needing such as repositioning and safety checks were not always being completed. These records were not being checked by the management to ensure people were receiving the care they had been assessed as requiring. This meant that the provider could not be sure that people were receiving good quality care that met their needs.

Previously we found that the medication audit was ineffective. It had not been identified that medicines were running out of stock, the incorrect doses of prescribed medication being administered and the times when people were receiving their medication may not allow there to be sufficient time between doses. At this inspection we found there were still concerns with the safe management of medicines which their audit had not identified and people were still not always receiving their medicines as prescribed. When we feedback our concerns the manager was not aware of the issues we found with the management of people's medicines.

We saw records within people's daily records that identified some unexplained injuries. The manager had not seen the records as they had been filed within people's daily records. The records had not been audited to ensure that the appropriate safeguarding action was taken to investigate the injuries. People were at risk of harm from abuse as the systems of reporting abuse were not effective.

These issues constitute a continued breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and the staff we spoke with told us they felt the service was well led and that the management and providers were visible within the service. One person told us: "The owners always make an effort to come and speak with us, they stop and have a chat". Another person said: "I recently received a letter of introduction from the new manager. I know the proprietor, he's very nice, he pops into the dining room to say hello and asks if everything is alright".

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems the provider had in place to monitor and improve the service were not always effective.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care and treatment that was safe.

The enforcement action we took:

We issued a warning notice asking the provider to improve.