Rodenvine (Nottingham) Limited

Parker House Nursing 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?	**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 29 June and 8 July 2016. Parker House Nursing Home provides accommodation for up to 25 older people, with or without dementia, who require nursing care or support with personal care. On the day of our inspection 24 people were using the service.

The service had a registered manager in place at the time of our inspection. 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.

Although risks to people were identified and assessed and people were supported by sufficient numbers of staff, risks were not always minimised by staff following good practice in relation to equipment and moving and handling.

People received their medicines when they needed them but the management of medicines required further improvement.

People felt safe in the service and staff understood their responsibility to protect people from the risk of abuse. We found that the registered manager had shared information with the local authority when needed.

People were not consistently asked for their consent before support was provided. Where people lacked capacity to do so they were protected under the Mental Capacity Act 2005. People were not deprived of their liberty without the required authorisation being applied for.

People were not always provided with timely support in relation to eating and drinking. Referrals were made to health care professionals for additional support or guidance if people's health changed.

People were cared for by staff who received training and support. We observed that staff were compassionate in their care and interactions with people who used the service.

People were encouraged to make choices about the care they received and people's privacy and dignity were respected by staff.

People told us that they felt that activities at the service were limited and we observed this to be the case during our visit. Records did not always show that people received care when they needed it.

People, and their relatives, told us they would feel comfortable making a complaint to staff or the registered manager. Records showed that complaints were responded to appropriately.

There were systems in place to monitor the quality of the service however these were not always effective in identifying issues within the service and the appropriate action being taken.

People felt that the management team were approachable and responsive to any concerns. People's views about the quality of the service they received were sought and staff felt they received a good level of support from the registered manager.

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.

Although risks to people were identified and assessed and people were supported by sufficient numbers of staff, risks were not always minimised by staff following good practice in relation to equipment and moving and handling.

People received their medicines when they needed them but the administration and management of medicines required further improvement.

People felt safe in the service and staff understood their responsibility to protect people from the risk of abuse. We found that the registered manager had shared information with the local authority when needed.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always provided with timely support in relation to eating and drinking.

People were not consistently asked for their consent before support was provided. Where people lacked capacity to do so they were protected under the Mental Capacity Act 2005. People were not deprived of their liberty without the required authorisation being applied for.

People were supported by staff who received appropriate training and supervision.

Referrals were made to health care professionals for additional support or guidance if people's health changed.

Is the service caring?

Good

The service was caring.

We observed that staff were compassionate in their care and interactions with people who used the service.

People were encouraged to make choices about the care they received and people's privacy and dignity were respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People told us that they felt that activities at the service were limited and we observed this to be the case during our visit. Records did not always show that people received care when they needed it.

People were supported by staff who had a good understanding of their preferences and support needs and care plans contained detailed information.

People, and their relatives, told us they would feel comfortable making a complaint to staff or the registered manager. Records showed that complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

There were systems in place to monitor the quality of the service however these were not always effective in identifying issues within the service and the appropriate action being taken.

People felt that the management team were approachable and responsive to any concerns. People's views about the quality of the service they received were sought and staff felt they received a good level of support from the registered manager.

Parker House Nursing 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.

We inspected the service on 29 June and 8 July 2016. This was an unannounced inspection. The inspection team consisted of one inspector, a specialist advisor who was a nurse 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, 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During the first day of our visit we spoke with five people who used the service, three relatives, three members of care staff, the cook, the administrator and the provider's representative. We observed care and support in communal areas. We looked at the care records of four people who used the service, staff training and recruitment records, as well as a range of records relating to the running of the service. As neither the registered manager nor the deputy manager were available on our first visit, we returned to the service to speak with the deputy manager and reviewed audits carried out at the service.

Requires Improvement

Is the service safe?

Our findings

Although care plans described how people's care needs could be managed safely, we observed that equipment and safe moving and handling techniques were not always being used in accordance with good practice. This meant there was a risk of care not being delivered safely. For example, we saw that pressure relieving equipment was in place for people at high risk of developing pressure ulcers although we found that one mattress was not at the correct setting for the person. We were told by a member of staff that they did not check pressure relief settings. This meant that the equipment may not be fully effective in reducing risks to people. In addition, we observed two people being supported with their mobility by staff who used methods to assist the person which were not considered good practice. The provider told us that they would arrange refresher training for staff in relation to moving and handling.

Risk assessments had been completed to assess people's nutritional risk, risk of developing pressure ulcers and falls risk. We found that these had been updated monthly. When bed rails were being used to manage the risk of a person falling out of bed, a risk assessment had been completed to ensure they were safe to use for the person. We saw that appropriate action had been taken in response to risks. For example, one person had been referred to an occupational therapist following a fall.

Guidance on how to support people in the event of an emergency such as admission to hospital or in the event of a fire was available to staff. We saw that people had personal emergency evacuation plans (PEEPS) in place, however this contained limited information about the support the person would require in terms of equipment and staff support in the event they needed to be evacuated safely from the service. Records showed that other safety checks were being carried out as required, for example in relation to; fire safety, water temperature and equipment.

People told us that they were happy with the way in which their medicines were managed and commented that staff waited with them whilst they took their medicines. However, we observed medicines being administered and saw on two occasions a member of staff did not always stay with the person to ensure they took their medicines as prescribed. The deputy manager told us that both of these people were safe to take their medicines unsupervised, and we saw records which documented this. This information was relocated to people's medicines administration records (MARs) following our feedback. We observed that people were not always offered a drink to help them take their medicines.

Some people's MARs did not have a photograph of the person to aid identification and of the ten MARs we reviewed, seven did not give any information on the person's preferences for taking their medicines. We saw that information about how people preferred to take their medicines was stored separately from MAR sheets at the time of our inspection. Following our visit, the provider confirmed that this information had been relocated to people's MAR records to help ensure consistency of medicines administration. Some medicines had to be handwritten on the MAR and when this had occurred, they had not always been signed by two people to ensure accuracy of information. Protocols were not in place to provide additional information for staff about medicines which had been prescribed to be given only as required. This meant that staff did not have clear information about when to give people these medicines. Some people were receiving their

medicines covertly and when this was the case we saw the person's family doctor had been involved in the decision and the pharmacist had been consulted. Medicines were stored securely and safely.

A nurse who was administering medicines on the first day of our inspection told us they had undertaken medicines training within the previous two months. Records showed that staff who administered medicines had their competency checked. Medicines spot check audits had been completed monthly in addition to more detailed medicines audits. We saw one of the actions identified from the audits was to ensure photographs were available within the MAR of people using the service. This was ticked as being actioned but was not found to be in place during our inspection. In addition, medicines audits had not picked up other issues identified during inspection such as the absence of PRN protocols.

People told us they felt safe at the service. One person told us, "I feel very safe," whilst another person told us, "I feel perfectly safe." The relatives of people who lived at the service also told us that they felt their relations were safe. One person's relative told us, "I've no concerns about [person] being safe."

People were supported by staff who had received training in protecting people from abuse and were able to demonstrate their knowledge during our conversations with them. The staff we spoke with were aware of the signs of possible abuse and told us they would report any concerns to the nurse or the manager who, they felt, would take action to address their concerns. They told us they would escalate concerns to the provider if necessary but were not sure about the role of outside agencies, such as the local authority, who have a lead role in investigating allegations of abuse. However, when we mentioned the local authority they said that they thought the relevant telephone numbers were displayed in the office in line with the services procedure. We found this to be the case. We found that the registered manager had shared information with the local authority when needed.

Most of the people we spoke with told us that staff were available when they needed support. One person said, "There's loads of staff around all the time," whilst another person said, "They (staff) come quite quickly when I ring (call bell for assistance). If they don't I ring again." People's relatives were also satisfied that staff were available to support their relation when needed. We observed that staff responded to people's requests for support and were responsive to call bells in a timely manner on the day of our inspection.

People needs were met in a timely way by sufficient amounts of staff. Most of the staff we spoke with told us there were enough staff on duty to respond to people's needs. One staff member said they needed an additional staff member in the morning due to the amount of people who needed the support of two staff to attend to their mobility and personal hygiene needs. The provider told us the staffing levels were adjusted to provide additional staff cover when required and provided us an example of when they had done so. We looked at staffing rotas for the service and saw that the required numbers of staff were regularly provided.

People could be assured that safe recruitment practices were followed by the provider to establish whether people were of good character and suitable to work with them. We checked recruitment records for two members of staff and saw that the service had taken the necessary steps to ensure people were protected from staff that may not be fit and safe to support them. Before staff were employed criminal records checks were undertaken through the Disclosure and Barring Service (DBS). These checks are used to assist employers to make safer recruitment decisions. We also saw that proof of ID and appropriate references had been obtained prior to employment and were retained in staff files.

Requires Improvement

Is the service effective?

Our findings

People were not always provided with timely support in relation to eating and drinking. We observed the lunchtime meal. We did not see that people were offered choices although were told that a vegetarian option was available. We witnessed that people who required support to eat their meals were provided with this, although due to the amount of people who required support, some people had to wait up to 20 minutes after other people at the table had been served. We saw that the majority of people who ate their meal in the dining room did not finish their meals and some people received little encouragement or interaction during the mealtime. People were provided with a hot drink at the end of their meal and there appeared to be a reliance on tea, coffee and milk as main fluid provision on the day of our visit. One person told us, "Sometimes I'd like a different drink. [Staff] don't ask me so I always get tea. I've always got water handy if I get thirsty." We fed back our observations of the meal time experience for people and the provider told us they would consider ways to monitor this. When we returned to the service, we saw that people were offered juice during their meal.

People told us the food was good although one person said that they were not routinely offered a choice of meals. Comments included, "It's excellent food, we get three meals a day. A good chef. It's a set menu really. They'd get us anything if we want a snack now and then," "The food is good. I just get what comes" and, "I'm quite happy with it. They can give us seconds too. It just arrives so no choice usually."

We spoke to the cook who told us that the registered manager had developed the menu based on the preferences of people using the service. Where people had specific dietary requirements such as a soft diet or gluten free food, we saw this was provided. We found that people were weighed in line with their care plans, records of people's food and fluid intake were maintained and referrals had been made to the dietician if people's weight had changed.

People were not consistently asked for their consent before staff provided support or assistance. People we spoke with told us that they were asked for their consent before care workers provided support, one person told us, "They always ask me if it's convenient to do something," whilst another person said, "I suppose they do ask us (before providing support)." We observed that people were usually asked for their consent and offered choices about caring interventions although we saw that protective clothing and meals were provided without explanation.

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's care records contained clear information about whether people had the capacity to make their own decisions. We saw that assessments of people's capacity in relation to specific decisions had been carried out when people's ability to make their own decisions was in doubt. If the person had been assessed

as not having the mental capacity to make a decision, an appropriate best interest's decision had been made and documented which ensured that the principles of the MCA were followed.

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 found that the registered manager was aware of the process for applying for an authorisation from the local authority and had done so for people who were deemed to be at risk of being deprived of their liberty. One person had a DoLS authorisation in place and the deputy manager confirmed that action had been taken in relation to a condition attached to the authorisation.

Most people we spoke with told us that they felt staff were suitably skilled to provide support for them although one person felt that more training was required in relation to moving and handing and the provider told us refresher training would be provided. Another person told us, "They're well trained and know what they're doing." The relatives we spoke with also felt that staff were able to carry out their duties effectively.

The provider told us in their provider information return (PIR) that, "A robust training matrix is in place, which covers all mandatory training, feedback is obtained verbally and is documented in staff supervisions for its development so as to ensure it is fit for purpose and relevant to the needs of the staff and the homes residents." Staff told us they had completed training which the provider had identified as being mandatory and were offered additional training opportunities. All of the staff we spoke with felt they had the knowledge required to carry out their roles effectively.

The staff we spoke with told us they had received an induction when they commenced working at the service which covered areas such as fire safety. Records showed that the majority of care staff had been enrolled on the 'Care Certificate' to ensure that they could carry out their roles effectively. The Care Certificate is a national qualification for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support.

People were supported by staff who received supervision and support from the registered manager. Staff told us that they had supervision with the registered manager on a regular basis and an annual appraisal to discuss their performance and development. We saw records confirming that a supervision plan was in place which provided staff with supervision every two months and that annual appraisals were being undertaken.

People were supported with their day to day healthcare needs although some people told us they were unaware of the availability of some healthcare services. One person told us, "They telephone the doctor as he's needed. I've not had anyone to do my eyes or teeth and no-one does my feet. The hairdresser comes in every week and a manicure lady does our nails now and then." Another person told us, "They're good at organising appointments. The chiropodist comes every few months too," whilst another person commented, "No-one ever comes to do my eyes or teeth." However, although not all of the people we spoke with were aware of services provided by external healthcare professionals we saw records which confirmed a number of people had been visited by the optician and chiropodist.

Records showed that referrals had been made to external healthcare professionals such as community nurses, occupational therapists and dieticians when people's healthcare needs had changed. We saw that the doctor had also been consulted and visited when people had shown signs of ill health. Records showed that a person with diabetes had access to diabetic screening and an annual diabetes review. We also found

that advice and guidance of external healthcare professionals were incorporated into people's care plans.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring and people felt listened to. One person told us, "They're all very good and caring. Lots of patience too." One person's relative told us, "They really do listen and care."

We observed that staff were compassionate in their care and interactions with people who used the service. For example, whilst waiting for a meal to arrive a care worker was talking to a person with advanced dementia, holding their hand and singing a war tune. We also saw that practical action was taken to relieve people's distress, for example, providing orientation to a person who was confused and providing distraction when a person displayed agitation. The staff we spoke with were knowledgeable about the people they supported and told us about how they support people with their care needs in a way which minimises distress, for example when attending to a person's personal hygiene needs when they were reluctant to have support.

Some of the people we spoke with told us that they found it difficult to understand some of the care workers. One person told us, "I think they (staff) are kind, yes. It can be difficult to understand, we've got quite a cosmopolitan staff here." We witnessed staff members talking with each other in their native language on occasions, at times talking across people who lived at the service who would not understand what was being said. The provider told that this would be discussed with the staff team.

People told us that they were involved in making decisions about their daily routine and that their decisions were respected. One person told us, "I'm able to wash myself when I decide." whilst another person told us, "We co-operate together. They (staff) help me do some things and give me a choice of clothes to see." People's relatives told us that they were involved in planning their relations care and we saw evidence that people's relatives had been consulted about people's preferences, life history and important decisions. One person's relative told us that they get invited to meetings whilst another person's relative told us, "We do it as a family and they often get in touch with us."

People had care plans in place which detailed their likes and dislikes and how they preferred to be supported. The care plans we accessed included considerable amounts of information about people's individual preferences which would suggest that people or their families had been consulted by the provider. Although none of the people we spoke with could remember being involved with their care planning or in reviews, the deputy manager showed us evidence of how some people had been involved in producing care plans and how people's relatives had been involved in reviews.

People's care plans contained good information about how staff could maximise communication with people to ensure that they were offered appropriate information and explanations. The registered manager told us in the PIR that an advocacy service was available to people if required. An advocate is an independent person who can provide a voice to people who otherwise may find it difficult to speak up. The deputy manager told us that no one at the service was currently using an advocate but explained the services available to people and gave an example of when they would consider the involvement of an

advocate.

People told us that staff respected their privacy and treated them with dignity. One person told us, "They're (staff) polite enough. They always knock too," whilst another person told us, "They do that for me (maintain privacy). Nice and private." We observed staff knocking on people's doors before entering and talking to people about issues of a personal nature discreetly.

Staff were aware of the importance of providing dignified care and respecting people's privacy. Staff gave examples such as ensuring that curtains were closed before providing care and giving people choices. Records showed that several staff members had registered as 'dignity champions.' A dignity champion is someone who takes action to ensure that care services are compassionate and person centered. We saw that people had information within their care plans which reminded staff of the principles of privacy and dignity and that staff meetings had been used as an opportunity to remind staff of the principles of maintaining people's dignity.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of not receiving care which was fully responsive to their needs as daily records of observations and re-positioning had not always been completed consistently. For example, records suggested that one person had not received staff attention for up to 10 hours during the night on two occasions. Another person's care plan had been recently updated to reflect that the person required observations at least hourly in order to maintain their safety. However, daily recording sheets showed that the person was only being checked by staff at two hourly intervals.

People were provided with limited opportunities to pursue their interests and social activities at the time of our visit. People told us that limited activities took place at the service. One person told us that since the activity co-ordinator had not been present at the service; "It's just TV and they (staff) put it on, we don't get asked. We're all bored stiff and they (people living at the service) just sleep. It gets very boring." Another person told us, "There's nothing goes on that I know of. I read my paper, watch TV or lie down."

We did not witness any activities taking place during the afternoon of our inspection and we saw that people were not consulted about what they wanted to watch on the TV. People told us that staff had limited time to enable them to spend time chatting to people who lived at the service. We observed this to be the case.

Individual files were kept for people to document their interests and involvement in activities up until the end of 2015 which evidenced that some people had obtained certificates from a local college. We were told by staff that the activities co-ordinator was not currently at work and in their absence the registered manager developed a rota to allocate a care worker to provide activities on a daily basis. We saw that a rota was in place and that the planned activity of massages on the day of our visit was provided to people on an individual basis over a two hour period in the morning. We observed one person receiving a massage and it was clear they were enjoying the activity. Following our visit the provider confirmed that the activities co-ordinator would not be returning to the service and they would be advertising to fill the position.

People felt their individual preferences were known by staff and they received the care they needed in the manner they preferred. One person told us, "They (staff) know me quite well now and when to leave me alone."

Staff we spoke with had a good understanding of people's needs and told us they found the care plans contained useful information. One staff member said, "Care plans are very useful and contain information about how to support people. We have time to sit and read care plans." We found that effective systems were in place to ensure that staff were aware of people's needs and preferences when they were admitted to the service. We saw that a range of care plans were in place to provide information on people's care and support needs. These were detailed and included information on people's preferences in relation to their care. We found that care plans were reviewed regularly and had been updated following any changes. For example, one person's mobility care plan had been updated following a fall.

Staff told us that they knew about people's history, likes and dislikes and preferences by talking to people or

reading their care plans. Care records contained a significant amount of information about people's backgrounds and what was important to them and care plans contained guidance as to how staff could support people to be as independent as possible. People confirmed that they felt their independence was encouraged by staff. One person told us, "Absolutely, they let us be independent," whilst another person said, "I'm able to wash myself when I decide."

People and their relatives who we spoke with during our visit told us that they had not had reason to make a complaint. Staff told us that if a person or their relative wished to make a complaint they would speak to the registered manager or suggest that the person spoke directly to the registered manager themselves. We saw that information was available within the service about how people could make a complaint and that suggestions were encouraged via the use of a suggestions box. We reviewed complaints made to the service over the previous year and saw that these had been responded to appropriately and action had been taken to address people's concerns.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes were in place to monitor the quality of the service; however these were not always effective. For example, medicines audits had not identified the absence of PRN protocols. Where issues had been identified, such as the absence of photos to aid identification on MAR sheets these had not always been addressed. In addition, issues such as equipment not being used correctly and the poor experience of people at mealtimes had not been picked up by quality monitoring systems within the service.

We saw that a range of monthly audits were carried out in areas such as falls, pressure ulcers and bruises. These records analysed incidents within the service and the action taken to try and reduce further incidence. For example, an increase in the number of falls at the service had been discussed at a subsequent team meeting and discussions about bruises sustained by people resulted in improvements to staff moving and handling techniques. Referrals to the local authority safeguarding team had been made appropriately and incidents had been investigated and discussed with staff if required. In addition, we saw that action plans had been produced when external agencies had visited the service and that appropriate action had been taken in response to any areas identified as requiring improvement.

People told us that they were happy living at Parker House. Although people and their relatives felt comfortable approaching the registered manager with any concerns they had, none of the people we spoke to could recall being asked their opinion of the service. However, we saw that quality monitoring surveys had been returned by some people and their relatives in 2015 which were complimentary of the service and made suggestions for improvements, particularly in relation to activities within the service. We saw that some improvements had been made in relation to people's suggestions, such as a photo board identifying staff, however activities remained an area that people felt could be improved.

People who lived at the service had the opportunity to attend meetings and be involved in the development of the service. For example, records showed that people had been involved in choosing the decor, how they would like to celebrate Christmas Day and what time they would like activities to be provided. We saw that some people's suggestions had been considered and acted upon by the registered manager. None of the people we spoke with could recall any meetings they could attend to discuss the service and make suggestions. In the PIR the registered manager had recognised that improvements could be made to gathering the views of people using the service, for example by having one to one meetings with people if preferred and encouraging attendance at group meetings.

Staff told us that the registered manager kept the day to day culture of the service under review. Records showed that regular staff meetings were held which discussed current issues in the service, such as if there had been an increase in falls and how to provide activities for people in the absence of the activities co-ordinator. One member of staff told us, "[Manager] gives feedback. We have meetings where we can raise questions and concerns. The manager will address issues with staff." Staff told us that they were aware of the service's whistleblowing policy and felt confident in raising any concerns without fear of reprimand.

People told us that they felt confident in talking to any of the staff if they had concerns about the care and

support they received at Parker House Nursing Home. All of the relatives we spoke with said that they would feel comfortable approaching the registered manager and would be listened to. One person's relative told us, "I've seen her at times. She's ok to talk to. We are listened to and will ask us how we are and how [Relation] seems." Another person's relative told us, "Yes, I know [Registered Manager] and absolutely can talk to her."

The service had a registered manager in post who understood their responsibilities. Records showed that we had received notifications when required. Providers are required by law to notify us of certain events in the service.

Staff told us that they were happy working at Parker House Nursing Home and described a close staff team who worked hard. One staff member told us, "We have a very good staff team here, we work together." Staff told us that both the registered manager and deputy manager were approachable and supportive. Neither the registered manager or deputy manager were available during our visit, however staff told us that there was always someone to contact if they needed advice or support. The provider's representative told us that contact numbers were available if staff needed support and we saw this to be the case.