Tamaris Healthcare (England) Limited

Park Farm Lodge

Inspection report

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21 April 2016

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

We inspected this service on 21 April 2016 and this was the first inspection under the new provider. We carried out this inspection as we had received concerns about how staffing was organised to meet people's assessed needs and we looked to see if the service was safe.

The service had a registered manager. 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.

Park Farm Lodge provides support and nursing care for up to 80 people. The service is divided into two units; one providing dementia nursing care for 40 people and the other for people who required nursing care for 40 people. There were 69 people living in the home on the day of our inspection.

There were not always enough staff available to deliver people's planned care. People did not always receive the support they needed and had to wait for support with personal care. The provider reviewed the staffing provided but this was not flexible and had not changed when new people moved into the service. Improvements were needed in this area.

There was a homely and relaxed atmosphere and people were generally treated with care and compassion. People told us the staff were kind and treated them respect. People liked the staff who supported them and had developed good relationships with them. People maintained relationships with their families and friends who could visit them at any time.

Staff understood the importance of safeguarding people and their responsibilities to report this. Staff knew how to recognise the signs of potential abuse and knew what to do when safeguarding concerns were raised.

Recruitment procedures made sure new staff were safe to work with people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not always safe.

There were insufficient numbers of staff to meet people's individual needs and keep people safe. Staff were kind and compassionate although care was task orientated. Recruitment procedures were in place to ensure new staff were suitable to work in the service.

Park Farm Lodge

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 21 April 2016 and was unannounced. We carried out this inspection because we had received concerns about the staffing provided. Our inspection team consisted of one inspector and one 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 service.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

On this occasion we did not ask the provider to send us 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. However we offered the provider the opportunity to share information they felt relevant with us.

We spoke with 11 people who used the service, six visitors, five members of care staff and the registered manager. We spoke with two social care professionals. We did this to gain people's views about the care and to check that standards of care were being met.

We observed how the staff interacted with people who used the service and we observed care and support in communal areas. Some people had communication difficulties, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at five people's care records to see if their records were accurate and up to date.

Inspected but not rated

Is the service safe?

Our findings

Some people who used and visited the service told us there were not always enough staff available to keep people safe and they needed to wait for personal care to be provided. People told us that the staffing provided was often so busy that this impacted on their care. We saw people had different experiences of the care provided. For example, within the nursing unit, we saw people wanted support from staff but had to wait. We heard one person shouting for assistance but there were no staff available and they had no means to summon support. Each lounge had a number of portable call pendants, but staff had not provided these to people. One person told us, "I have to keep shouting because there's no staff and I forgot to ask for a call bell."

We saw that there were not always enough staff to support people to retain their independence and dignity. We saw people were offered drinks but staff did not always stay to provide support when people needed it. We had to support one person who dropped their cup onto their lap and spilt their drink on their clothes. One person struggled to raise their cup and only took small sips. At lunch time they were still trying to drink the same cup of tea which had been served mid-morning and was now cold.

At lunch time we saw a large number of people needed individual support to eat their meal in their bedroom. One member of staff was present in the dining room and helped to serve the meals. We saw three people sat and waited and watched people eat their meal before other staff were present to give them support. One member of staff told us, "It's always like this. People have to wait because there isn't enough staff to provide all the individual support we need to especially at meal times."

The provider monitored the numbers of staff on each shift and considered how the staffing provided met people's dependency needs. However, we saw that new people had moved into the service but the staffing had remained constant and there had been no changes to the number of staff provided. One member of staff told us, "More people have moved here but we don't have any more staffing. It gets really difficult at some times throughout the day." One relative told us, "There are not enough staff; I feel sorry for the staff, they never stop, they are run ragged."

The above evidence demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first floor, we saw people had different experiences as there was a member of staff in the main lounge who was available to provide support. One member of staff told us, "There is generally someone around for people. We have to be aware that people have differing needs, so it can be difficult to juggle things. [Person who used the service] likes to sing and we have a cupboard full of things that people can do, like memorabilia. It's nice to have the time to do things with people." Some people had chosen to stay in their room and one member of staff told us, "People have a right to choose whether they want to stay in bed. We have the same number of staff on duty whatever people decide, but if people want to stay in their room we have to make sure they are also checked so they are safe." We saw staff had time to speak with people and spent time talking about their family and what they liked to do.

Although staff support was generally task orientated people spoke positively about the support they received from staff. One person told us, "I've got nothing to complain about. I'm looked after marvellously. I feel safe as houses here." Another person told us, "The staff are really lovely." A relative told us, "I feel they are safe here. They've been in different places and this is the best. I've got no complaints; they look after me as well." Staff knew people and understood how they needed to support people according to their preferences.

Risks to individuals were recognised and assessed and staff had access to information about how to manage the risks. Staff understood how to support people and we saw when people were supported to move with the aid of a hoist, staff were attentive and spoke to people throughout the procedure. One person told us, "The staff are very kind and help me to move around. I'd be lost without this support." One member of staff told us, "We have lots of different equipment so we can move people safely."

The staff showed they were aware of how they should report any safeguarding concerns. They were also able to demonstrate understanding as to what situations were considered as unsafe or as abuse. One member of staff told us, "We know what abuse is and how this can affect people. If we see anything we are concerned about then we report it." Another member of staff told us, "I don't mess about. If something's wrong then I'd make a call. I know we can report things directly to you or the local authority. We've seen where this has been done in the past, action has been taken." Where safeguarding concerns had been raised, the registered manager had notified us of these incidents as required and worked with the local authority to ensure incidents were investigated and people were safe.

When new staff started working in the service, the staff told us that that recruitment checks were in place to ensure they were suitable to work with people. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. The recruitment records confirmed these checks had been completed prior to new staff starting to work in the service.

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 did not take formal enforcement action at this stage. 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 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of skilled and experienced staff were not suitably deployed in order for people to receive safe compassionate and effective care.