Kendalcourt Limited

Home Park Nursing Home

Inspection report

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Date of inspection visit: 30 & 31 October 2014
Date of publication: 23/03/2015

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

Overall summary

This inspection took place on the 30 and 31 October 2014 and was unannounced.

Home Park Nursing Home provides accommodation for up to 35 older people who require nursing, respite or end of life care. Many of the people being cared for at the home are also living with dementia which means their ability to understand and communicate their needs and wishes is limited. Most people were dependent on the staff to meet all of their care needs. At the time of our inspection, there were 34 people living at the home.

Home Park Nursing Home is an older style house set in large grounds in a rural location in Hampshire. The accommodation is arranged over two floors with a lift available for accessing the first floor. The home has 23 single rooms and six shared rooms.

Summary of findings

A registered manager was 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff deployment required improvement. People were not always adequately supervised and had to wait for support and assistance during key periods of the day such as at mealtimes. Staff did not have the time to provide meaningful interaction with people.

Cleanliness and hygiene standards in the home required improvement. We saw some poor infection control practices which placed people at risk of transferring or acquiring infections.

The management of medicines required improvement. Appropriate arrangements were not in place for checking the expiry date of medicines. We could not be assured that records contained sufficient information to ensure the consistent administration of 'as required' medicines to people. Arrangements were not in place to ensure staff had the competency and skills needed to safely administer medicines.

People were not consistently protected from the risk of abuse. A safeguarding incident had not been reported to the local authority safeguarding unit or to the Care Quality Commission (CQC). It was not clear to us that following the incident, the home had put in place a full range of preventative measures to prevent the risk of similar incidents occurring.

Recruitment procedures were in place to ensure that only suitable staff were employed. However these were not fully effective. Appropriate references had not always been obtained and checks had not been made to ensure that applicants were physically and mentally fit for work

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had not always sought and acted in accordance with relevant guidance where people's freedom was being restricted.

People were not supported to take part in a comprehensive range of meaningful activities. We observed people spent long periods of time without stimulation or meaningful interaction. We looked in five people's records and found low numbers of recorded activities.

People did not always receive care which was dignified and respectful. People were not supported to eat their meals in a manner which respected their dignity. Some interactions appeared entirely task focused and we noted that some staff did not readily engage with the people they were supporting.

Improvements were needed in relation to how the provider and registered manager identified, assessed and managed risks relating to the safety of people and of the quality of the service. We identified concerns in a number of areas. These included dignity and respect, protecting people from harm, medicines management, cleanliness and hygiene and the recruitment procedures. These issues had not been identified by the provider or the registered manager before our visit, which showed that there was a lack of robust quality assurance systems in place.

Whilst overall, the care plans and records were of a good standard, there were some aspects that could be improved, for example, none of the records we viewed contained a care plan in relation to the person's end of life wishes. People living with dementia did not have a detailed care plan which gave staff specific and personalised guidance about how they should meet the person's care and support needs, although elements of this were contained within people's other care plans such as their nutrition and hydration plans and their personal care plans.

People's care plans did not always provide all of the necessary information to ensure staff were able to respond quickly to people's changing needs.

The programme of training needed to be further developed to ensure that staff continued to receive all of the essential and relevant training required to carry out their roles and responsibilities effectively. For example, Mental Capacity Act and Deprivation of Liberty Safeguards training had yet to be rolled out to all staff.

The provider had policies and procedures in relation to the Mental Capacity Act (MCA) (2005) and a copy of the

Summary of findings

MCA code of practice was available within the home. Whilst staff had yet to receive formal training on the MCA, they were able to describe some of the basic principles of the Act.

The registered manager had developed effective working relationships with a number of healthcare professionals to ensure that people received co-ordinated care, treatment and support. The records confirmed that guidance and instructions from these professionals were acted upon.

The provider had a complaints procedures which was readily available to people and their relatives. We saw that complaints or concerns were used as an opportunity to learn and improve the care and support provided to people.

Most people living at Home Park Nursing Home were unable to tell us their views about the leadership of the home. One person did tell us they had no complaints about how the home was managed. A relative told us that they felt comfortable talking with the registered manager about any queries or concerns.

Staff told us that the home was well led and that the management team were supportive and approachable and that there was a culture of openness within the home which allowed them to make comments or suggestions about how the service might improve.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 safe.

People were not always adequately supervised and had to wait for support and assistance during key periods of the day such as at mealtimes.

Medicines were not always managed safely and arrangements were not in place to ensure that staff handling medicines had the competency and skills needed to manage this safely.

We observed poor infection control practice which put people at risk.

The registered manager had not recognised or reported a safeguarding incident to the Local authority safeguarding unit or to the Care Quality Commission (CQC).

Is the service effective?

Requires Improvement

The service was not always effective.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager had not always sought and acted in accordance with relevant guidance where people's freedom was being restricted.

Staff varied in the amount of training they had received and how up to date it was. Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training had yet to be rolled out.

Further work was needed to ensure that each person who lacked capacity had a clear mental capacity assessment which supported staff to act and make decisions on their behalf and in their best interests.

Staff had regular supervision and appraisal and they felt well supported. This helped them to perform their role and responsibilities effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported to eat their meals in a manner that respected their dignity.

Many staff were very attentive and spoke in an encouraging and kind manner when supporting people. However other interactions appeared entirely task focused and we noted that some staff did not readily engage with the people they were supporting.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Summary of findings

Care plans although mainly detailed and person centred did not contain all of the information needed to ensure that each person received care which was responsive to their needs.

There were insufficient activities taking place. There was a risk of some people experiencing social isolation. There was no activities co-ordinator and staff did not have time to engage in activities or provide companionship to people who were cared for in their rooms.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits were not used to deliver improvements in the quality of care. We found a number of concerns during the inspection which had not been identified by the provider or registered manager. This showed a lack of a robust quality assurance system.

Staff were enthusiastic and motivated to do a good job. They said morale amongst the staff team was good.

Home Park 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 checked 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 was an unannounced inspection which took place over two days on 30 and 31 October 2014.

On the first day, the inspection team consisted of an inspector, a specialist nurse advisor in the care of frail older people living with dementia, 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 service. Our expert had experience of supporting people living with dementia and of using health and social care services. On the second day, the lead inspector was accompanied by a second inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the 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. We used this information to help us decide what areas to focus on during our inspection.

We spoke with three people who used the service. Most people were not able to talk with us about their experiences of living at the home and the care they received. We therefore spent time observing the care and support provided. 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 also spoke with seven relatives

We spoke with the provider, registered manager, administrator, cook, three registered nurses, four staff members and a nursing student. We reviewed the care records of six people in detail and the records of four staff. We also viewed other records relating the management of the service such as the medicines administration records, training records and policies and procedures.

Following the inspection we contacted four community health or social care professional to obtain their views on the home and the quality of care people received.

The last inspection of this service was in September 2013 when no concerns were found in the areas looked at.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Home Park Nursing Home. A relative told us, "My [relative] is safe and well looked after". Another relative said, "The care home is wonderful. My [relative] is content and safe". Whilst people told us they felt safe, through our observations and discussions with people and staff we found aspects of the care provided was not safe.

The registered manager said the target staffing levels during the early shifts were two nurses and seven staff members. During the late shifts, two nurses and six staff members were on duty until 6pm. Night shifts were led by one nurse and three staff members. We reviewed the rotas for a four week period, these confirmed that the home was staffed to these target levels. We asked people if they felt the staffing levels were adequate. Their views were mixed. One person told us there were enough staff. A second person felt there were insufficient staff, but they were not able to tell us why or how this affected them. Relatives also gave us mixed feedback. Two relatives told us there were insufficient staff. One said, "I am happy with the staff, but there are not always enough of them". A second relative said, "The staff here are good, but are really busy….during shift changes, residents are left on their own and they can't call out for themselves". However three relatives told us that the staffing levels were adequate. One said, "There are enough staff and they are very attentive".

Most staff felt that the current staffing levels were safe and people were appropriately supported. However, two staff said they were not always able to provide care in a timely manner. One staff member said they were not able to reposition people or help them to use the toilet as much as they would like. They said, "We are always playing catch up". Our observations indicated that there were not always sufficient numbers of staff to ensure that people were kept safe and their needs met. During the morning we spent time in the main lounge observing people's care and support. On three occasions there were periods of 10 -15 minutes when the lounge was not supervised and staff were not available to support people. One of the people seated in this lounge was often restless and displayed behaviour which could have placed them at risk of falling. When staff were in the room, they intervened to support the person, however we were concerned that there were periods when there were no staff available to help ensure this person was kept safe.

Staff did not have time to provide meaningful interactions with people as they were busy carrying out routine care tasks. When staff entered the lounge to carry out tasks such as serving the morning coffee, we saw that they did interact with people who appeared to respond positively to this. However at other times, people were sat for long periods of time with no interaction and no engagement apart from staff briefly speaking with them in passing.

There were insufficient staff to ensure that people received the required level of support with eating in a timely manner. During lunch we observed that one person had their meal placed in front of them at 12.10pm, but a staff member was not available to assist them to eat their meal until 12.20pm. The staff member assisting this person left on three occasions to support other people. This person's pudding was again placed in front of them for 15 minutes before a staff member was available to support them. We observed similar delays in people receiving their meal in the other lounge. In some instances meals had been left on the table for 20 minutes before staff were available to support people. We were concerned that the staffing levels did not have the flexibility to meet people's needs at meal times.

There were insufficient numbers of staff available at all times to meet people's needs. People were not always adequately supervised and had to wait for support and assistance and staff did not have the time to provide meaningful interaction with people. This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The home looked clean, but there were problems with some aspects of the cleanliness and hygiene in the home. There were some poor infection control practices which could place people at risk of harm. For example, areas of the home and some equipment had not been adequately cleaned or had been poorly maintained. We saw that three of the hoists used within the home had rust on their base supports. Some of the seating in the lounge was in a poor state of repair with exposed foam on the arm rests. The

seats of six commodes which were being regularly used were worn. These items would be difficult to clean effectively and this could pose a risk to people of acquiring infections.

Two people living at the home had a type of bacterial infection that was resistant to a number of widely used antibiotics. This meant it could be more difficult to treat than other bacterial infections. We found a cushion belonging to one of these people in another person's room. This increased the risk of others acquiring or transferring this infection. In one toilet we noted there was a bin, but this did not have a lid. The bin contained some used continence products. This was not a hygienic or safe way to dispose of clinical waste products.

Staff were diligent about wearing aprons and gloves when performing personal care or serving food. However the registered manager had not appointed someone with appropriate skills and knowledge to be an infection control lead and take responsibility for the infection prevention and control measures within the home. When we reviewed the training records, we found that out of the five housekeeping staff, three had not completed infection control training. We also noted that eight of the 21 care staff had also not completed training in this area. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The management of medicines required improvement. Two medicines that could be required in an emergency were past their expiry date. We could not be assured that these medicines were safe to administer to people. Fifty per cent of people at the home were prescribed PRN medicines (which can be given 'if required') for example for pain control. Most people would not have been able to tell staff that they were in pain. There was no guidance for staff about when these should be given. We could not be assured that people received their prescribed medication when they needed it.

Medicines Administration Records (MAR's) showed errors. One person had not received their medicine prescribed for administration at 8am until 11.45. On the two remaining MARs we noted a recording error had occurred that day. The nurse administering the medicines told us they had been "really nervous doing the drugs today". They explained that they had just returned to work after an extended absence. We asked if they had received any refresher training in the safe administration of medicines, they told us that there had not been time to do this. We were concerned that arrangements were not in place to ensure staff handling medicines had the competency and confidence needed to manage this safely. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Appropriate systems and processes were in place for obtaining and storing people's medicines, including controlled drugs were stored securely and safely and at the correct temperature. We completed an audit of the controlled drugs in stock and found records were accurate. Controlled drugs which are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971.

People were not consistently protected from the risk of abuse. Whilst the organisation had appropriate policies and procedures which included relevant information about how to raise safeguarding alerts, the registered manager had failed to recognise an allegation of abuse. The registered manager had not reported the allegation to the Local authority safeguarding unit. Notifying the local authority is important as they need to be able to decide whether the issues raised require a protection plan to be put in place. The Care Quality Commission (CQC) had also not been informed of this incident. Organisations are required by law to notify the CQC without delay of any allegation of abuse. This concern had subsequently been looked into under safeguarding processes and the CQC have received the relevant notification. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Recruitment procedures were not consistently robust to ensure that only suitable staff were employed. The registered manager had sought references, but in two cases these had not been obtained from the person's previous employer even when this related to work in health and social care. These checks are important as they help to ensure that potential staff are of good character and have shown satisfactory conduct in similar roles. This is a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Checks were made with the Disclosure and Barring Service (DBS) before employing any new member of staff. The registration details of nursing staff had been checked with the body responsible for the regulation of health care professionals and these checks were repeated on an

Inadequate

Is the service safe?

annual basis. The registered manager was aware of the process to follow to ensure that staff that were no longer fit to work in health and social care were referred to the appropriate bodies.

People's records contained appropriate risk assessments which covered a range of areas. For example, we saw assessments had been undertaken to identify whether people were at risk of choking when eating. Where people were at risk of pressure ulcers, care plans contained information about how this risk was to be managed and a completed pressure ulcer risk assessment. Detailed moving and handling risk assessments were also in place. Staff members told us that the risk assessments told them what they needed to know about each person and how to deliver their care safely.

Requires Improvement

Is the service effective?

Our findings

A person told us they were pleased with the care and support they received. They said, "I am well looked after". A relative told us, "I am happy with the staff, they are adequately trained…they have lots of refresher courses. A social care professional told us, "Home Park is very good at supporting people with quite significant dementia, including behaviour that challenges…their care to manage these behaviours is respectful to the individuals and is well thought out…the care plans are good…the care provision runs very smoothly". A healthcare professional told us that they thought "very highly of the home". They felt the home provided effective support which meant that people with quite complex needs had settled in their care.

As most people were not able to tell us how effective the service was in meeting their needs, we spent time observing how they experienced the care and support provided. We found that people did not always receive effective care.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. The registered manager had not always sought and acted in accordance with relevant guidance where people's freedom was being restricted. We saw an example of a restrictive practice being used to prevent a person from damaging their skin. We reviewed this person's care plan and found that the person had not consented to the restriction. There was no mental capacity assessment or risk assessment which justified or supported this practice being used as a last resort to protect the person from further harm and there was no DoLS authorisation in place. This meant the provider had not ensured that all of the required legal protections were in place to ensure restrictions of people's freedom were not unlawful or otherwise excessive. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The training programme was mostly via on-line courses and included essential training such as safeguarding people from harm, dementia care and end of life care. The registered manager told us that they discussed staff competency in supervision so that they could be assured that staff had understood the training received. Some staff had completed training in additional subjects such oral hygiene, nutrition and dysphagia. Dysphagia is when people have difficulties or discomfort when swallowing. Staff confirmed that they had received training in moving and handling within the past year which had included a practical assessment of their competency. Some of the registered nurses had also been trained in other subjects such as the use of equipment that managed people's pain when receiving end of life care, maintaining skin integrity and catheter care. Staff were being supported and encouraged to undertake nationally recognised qualifications in social care.

There were also some gaps in staff training. Only three out of 21 staff members had completed equality and diversity training and 13 staff members had not yet completed training in dignity awareness. Only five staff members had completed first aid training. We saw action was being taken to update and revise the training schedule and a learning profile for each member of staff was being developed. Additional online courses were being rolled out to all staff. This needs to be further embedded to ensure that staff continue to receive all of the essential and relevant training required to carry out their roles and responsibilities effectively.

When staff started work at the home, they received an initial induction which included shadowing more experienced staff and covered their familiarisation with the environment, the people living at the home, and the policies and procedures of the organisation. The induction was in line with Skills for Care Common Induction Standards (CIS). These are the standards people working in adult social care should aim to achieve within their first 12 weeks. They help to demonstrate that the staff member understands how to provide good quality care and support.

Staff said they received regular supervision and that they were satisfied with the support they received from the registered manager. One member of staff said they were able to raise any issues with the registered manager within supervision or before if important. Supervision sessions were a mixture of short one to one meetings and practice

Is the service effective?

based observations. Brief records of these sessions were maintained. Staff also received an annual appraisal of their performance which considered their strengths and weaknesses, personal effectiveness and training needs.

Staff described how they tried to support and empower people to make decisions for themselves. However, most people were unable to give valid consent to the care provided by staff and so we checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act (MCA) 2005. The Mental Capacity Act is a law that protects and supports people who do not have the ability to make decisions for themselves.

The provider had policies and procedures in relation to the Mental Capacity Act (MCA) (2005) and a copy of the MCA code of practice was available within the home. Whilst staff had yet to receive formal training on the MCA, they were able to describe some of the basic principles of the Act. We found some people's capacity to make decisions and choices had been assessed. Where people were deemed to lack capacity, appropriate consultation had been undertaken with relevant people such as GP's and relatives to ensure that decisions were being made in the person's best interests. However, some of the assessments needed to be updated and others were yet to be completed. The registered manager was aware that further work was needed to ensure that each person who lacked capacity had a clear mental capacity assessment which supported staff to act and make decisions on their behalf.

People told us they enjoyed the food provided at Home Park Nursing Home. A person told us, "They cook all the food here themselves". A relative said, "I feel [my relative] is getting enough to eat and drink". People's nutritional needs were assessed and care plans were in place which described the support each person needed to eat and drink. People were assessed using nationally recognised risk assessment tools to determine whether they were at risk of malnutrition. Where people were at risk of malnutrition, or were experiencing difficulties with eating or swallowing their food, they were referred to specialists such as speech and language therapists in a timely manner.

People's weights were monitored on a regular basis. Food and fluids charts were used to monitor people's dietary intake where necessary which included a target intake amount for each day. During the inspection, most people were being supported to have regular fluids throughout the day. Although we did note whilst walking around the home, that in three rooms upstairs, where people were cared for in bed, there were no fluids available in their rooms. We were concerned that this could make it more difficult for staff to encourage and offer fluids on a regular basis.

Detailed information was readily available for staff about specialist diets and guidelines for adding thickener to drinks. One staff member explained in detail the difference between soft and puree diets. They described how they ensured those on fortified diets had additional calories through the use of fortified milk, yoghurts, nutritional drinks and smashed bananas. We spoke with the chef. They explained that they had plans to introduce a new menu to enhance the food choices available to people. They told us that when making a pureed meal, they ensured that each of the elements of the meal were pureed separately so that the person could still taste the individual flavours. They were kept informed about people's particular dietary requirements and whether people were losing weight or not eating so well. This enabled them to consider additional measures or options to enhance their food intake.

The registered manager had developed effective working relationships with a number of healthcare professionals to ensure people received co-ordinated care, treatment and support. A local GP visited the home on a weekly basis during which time they liaised with staff to review people's healthcare needs. Effective links had also been developed with the local Mental Health Team, chiropodists and dental services and a tissue viability nurse. Records confirmed guidance and instructions from these professionals were acted upon. The healthcare professionals we spoke with confirmed staff at worked effectively with them. The service had made arrangements for each person to have a hospital passport. This documented important information such as how hospital staff might best communicate with the person or key information about their physical and mental health when they may not be able to explain this themselves.

The building was not well designed to support the needs of people living with dementia. The layout of the building was not easy to follow and that there was a lack of measures such as contrasting colours, good signage and effective lighting. We saw that a programme of repair and

Requires Improvement

Is the service effective?

redecoration was underway. We recommend to ensure this programme is effective, the provider explores the relevant guidance on how to make environments used by people living with dementia, more dementia friendly.

Requires Improvement

Is the service caring?

Our findings

People spoke positively about the care provided by the staff as did their relatives. One relative said, "I think the home is brilliant, the staff are friendly and conscientious". A social care professional told us, "Staff present as very kind and caring, knowledgeable about each [person's] individual likes, dislikes and who they are as individuals". A healthcare professional told us that people were "Cared for very well". We saw a number of relatives had given positive feedback to the home about the care their loved ones had received at the home. Comments included, "A very caring environment", "caring and attentive" and "They maintained [the person's] dignity".

People were not always supported to eat in a manner that was dignified and respectful. For example, some people were not supported to eat their meals in a manner that respected their dignity. Two people were being helped to eat by staff who were standing up. Staff did not wait until people had finished their meal before moving away to attend to other tasks. One person who was able to eat and drink independently had only been given a spoon and they were struggling to cut up their food. All of the people in one lounge were served their main meal in a bowl rather than on a dinner plate. This approach lacked dignity. Some staff did not readily engage with the people they were supporting. For example, we saw one person being helped to eat with very little communication from the staff member. We observed staff members talking amongst themselves whilst supporting people to eat and drink. A person was helped to eat their meal without being told what they were eating. We could not be assured therefore that each person was getting the support they needed to make their mealtimes a pleasurable experience. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed some staff speaking to people with patience and warmth. We saw a staff member give a person gentle encouragement to prompt them to eat and drink. We observed a person being supported to move from their chair into a wheelchair. The staff member constantly reassured the person and guided and directed them on what to do. When the task was completed, the staff member told the person they had been "Amazing" and praised them for their efforts. Staff assisting a person to stand using a piece of equipment, two staff spoke with the person, reassuring them and encouraging them to be involved as much as they were able to. They gave the person clear instructions. The person responded positively to the staff and the process of assisting the person to move was completely sensitively and discreetly. We saw people were clean, well groomed and well dressed. A relative told us their loved one was always "Clean and tidy" when they visited.

Relatives told us they could visit when they wanted and were made to feel welcome within the home and they appeared at ease with staff and in the environment. Staff had worked with people and their families to create a 'This is me' document which contained some information about people's life histories and their preferred daily routines. For example one person's plan stated what they liked for breakfast. Another plan recorded that the person liked to have classical music on in whilst in their room. When we visited this person, we found that their radio was playing classical music but this was on so quietly it could barely be heard. We saw from the minutes of team meetings staff were reminded about the importance of respecting people's choices. For those with specific religious beliefs, monthly visits were made by the local church so that people were supported to maintain their faith.

People could be better supported to make decisions about their care. The registered manager told us, "It's not easy with our client group to get them involved in care planning, we ask them about their likes and dislikes and give people choices, but this is difficult due to their dementia". We found some evidence that people were supported to make decisions. For example, a staff member told us, "I ask [people] what they prefer, I make sure they understand". Another staff member said, "I ask [people] , some understand, some don't but I keep talking to them and I'll try and help them choose clothes. People were not always given time to express their choices. For example, one person was offered the choice of steak and kidney pie or fish, they were encouraged to make a choice, they did not answer and so were given steak and kidney pie and told to wait for someone to help them. A relative told us, "The food is nice but there is often no choice".

The registered manager told us they spent time walking around the home, observing care and listening to the manner in which staff interacted with people. This helped them to be reassured that people were receiving dignified and respectful care. There was a dignity champion whose

Requires Improvement

Is the service caring?

role was to educate and inform the staff team about dignity in practice. The dignity champion had developed signs which were placed on people's bedroom doors to alert staff and visitors that the person was receiving personal care. In the shared rooms, we saw that new curtains were being installed to provide additional privacy. The dignity champion also maintained a notice board for staff with examples of what dignified care should look like. We saw that through the use of a dignity diary, examples of dignified care were celebrated and shared with the wider staff group. The registered manager told us that any observations of undignified care were followed up with the staff member concerned. Whilst these measures were useful tools in ensuring people received dignified care, they had not been completely effective in identifying and addressing all the areas where practice could be improved and so further improvements were needed in the way in which the service assures itself that all staff understand how to respect people's dignity.

Requires Improvement

Is the service responsive?

Our findings

Some people were unable to be involved consistently in the assessment of their care because of their level of dementia. Where people were unable to contribute to their plans we saw that their relatives were usually consulted. One relative said, "I discuss the care plan" and "Staff listen to my opinions". Another person said, "My husband has a care plan and I participate in any changes to this". Whilst most relatives told us they were happy with the level of involvement they had in care planning, two relatives told us that they would like more opportunities to be part of this process.

People were not supported to take part in a comprehensive range of meaningful activities. One relative who visited daily said, "There are no activities and minimal social stimulation". Another said, "Activities include music about once a month, there is a lack of stimulation". NICE Guidance: Quality Standards for Supporting People to Live Well With Dementia states "It is important that people with dementia can take part in leisure activities during their day that are meaningful to them. This helps to maintain and improve their quality of life". People spent long periods of time without stimulation or meaningful interaction. Two hours after lunch had finished, we saw two people were still sitting at the table with no obvious occupation. One person told us that they enjoyed gardening, but that there had not been an opportunity to follow this hobby since living at the home.

People cared for in their rooms lacked regular and meaningful interaction. Staff did not sit and talk with the people unless they were providing care. Spending time with people is important as this helps people to feel valued. One person's care plan stated "I dislike being on my own". We did not see staff visit this person other than to provide their routine care. The registered manager told us there had not been an activities co-ordinator employed by the service for almost year. They said, "We do what we can if staff have time". Staff told us they did not get the time and would value additional time to spend with the residents. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Whilst overall, the quality of people's care plans was good, we did find some examples where additional information would ensure that staff were able to respond quickly to people's changing needs. For example, one person had a chest infection. The care plan for this was brief and did not address the range of symptoms the person might experience. This person was also recorded as displaying a repetitive behaviour. We could find no recent records to suggest that the causes or triggers for this behaviour had been recently investigated. We spoke with a member of the nursing staff about this. They agreed to contact the GP for a review of the person's behaviour. Three people had recently had urinary infections. During the time of the infection, we found that interim or short term care plans had not been put in place to ensure that staff were able to manage their symptoms. We also noted that there was no preventative care plan which described the signs and symptom that the person might display if they were developing a urine infection.

We observed one person constantly tried to place their legs on a table that had been placed near their chair. Some staff members appeared to be aware the person should not have a table nearby because this was a known behaviour and increased their risks of falls. Others assisted the person to lower their legs but replaced the table. There was no guidance in this person's care plan about how staff should respond to this person's behaviour in order to ensure her welfare and safety.

We found other care plans did contain detailed information about people's needs such as personal hygiene, eating and drinking, continence care, medication and mobility. We also found some care plans did not just relate to people's immediate needs but also anticipated situations. For example, care plans contained detailed guidance about the actions staff should take if a person choked. A staff member told us, "We know that some people can choke in care homes so we all know what to do". Another person had a diabetes plan, which gave guidance about how staff should respond if the person's blood sugar readings fell below a certain level.

We saw that in another person's plans, information was provided not only about the types of protective creams they required, but the way in which this should be provided. The guidance said, "Talk to [the person] make them feel comfortable". The inclusion of this guidance supported staff to deliver responsive care and reduced the risk of the person becoming resistive or distressed during the intervention.

The provider had a complaints procedure which was readily available to people and their relatives. Whilst most

Requires Improvement

Is the service responsive?

people living at the service would not be able to understand the procedures, their relatives confirmed that they were comfortable raising any concerns with the registered manager. We looked at a summary of the complaints the provider had received in 2014. The registered manager had responded in a timely manner and the records showed each was thoroughly investigated and that appropriate actions had been taken to address the concerns.

People's relatives were encouraged to give feedback about the service. There was a feedback book by the front door and the provider had recently signed up to an online feedback service which they hoped would increase the opportunities for relative or professionals to leave feedback about the service.

Requires Improvement

Is the service well-led?

Our findings

Most people living at Home Park Nursing Home were unable to tell us their views about the leadership of the home. One person did tell us they had no complaints about how the home was organised. A relative told us that they felt comfortable talking with the registered manager about any queries or concerns.

The registered manager had a number of quality assurance processes in place to monitor quality and safety within the home. However, these were not being fully effective in driving improvements.

During the inspection we identified concerns in a number of areas. These included dignity and respect, care and welfare, protecting people from harm, medicines management, cleanliness and hygiene and the recruitment procedures. These issues had not been identified by the provider or the registered manager prior to our visit. For example, we saw the audits of people's medicines records showed that for almost a year, concerns were being noted on a regular basis that staff were not recording the date that creams and ointments were being opened. This is important to ensure that the creams are remaining effective.

Audits were not used to deliver improvements in the quality of care. An audit completed in April 2014, had identified a number of concerns including; lack of stimulation, television and music on too quietly, that a toilet area was blocked by a wheelchair and that there were no drinks in some rooms. These were similar to the concerns that this inspection was highlighting. For example, we found that throughout the home there was a lack of safe storage areas for equipment such as hoists, wheelchairs and walking frames. These were therefore being stored in bathrooms, toilets and corridors. We saw that one person had to ask a staff member to remove the items from a toilet area so that they could access this independently. The registered manager had highlighted in the provider information return that they planned to review the audit tools to ensure that they were being effective in highlighting areas where action or improvements were needed.

There was not an effective system of assessing and monitoring the quality of service provision. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider and registered manager did not have a service improvement plan in place. A service improvement plan is a detailed formal plan that sets out and prioritises the improvements that the provider hopes to make to service delivery. It considers the resources needed to achieve these and the timescales within the improvements should be made. These plans help to drive continuous improvement. We found that improvements or changes were managed in a reactive rather than proactive manner following incidents, complaints or comments.

Regular monitoring and checks of the water system were not taking place. This is important to ensure that temperatures remain within the parameters recommended to prevent the growth of legionella bacteria. We spoke with the provider about this, they have informed us that they have requested that a plumber visit and advise on how this can be best achieved for the service. We will check that this has been completed The provider had commissioned an external contractor to undertake an annual risk assessment for legionella. In addition, records showed that the water being discharged from taps in two rooms was in excess of recommended temperatures. Since the inspection, work has been completed to install regulators which will ensure that water is discharged from the taps at safe temperatures.

A record was kept of incidents and accidents within the home. These were reviewed by the registered manager and appropriate actions had been taken to reduce the risk of reoccurrence. We saw that the registered manager had recently developed a new protocol to be used following a fall. The registered manager told us that it was hoped that this would help to inform the risk assessment process. It was too early for us to assess the impact of this.

The registered manager encouraged open communication with relatives and staff. A monthly newsletter had been developed to keep relatives informed about changes or developments within the service and copies of this were kept by the front door. A satisfaction survey had recently been undertaken with relatives. The results from this were yet to be analysed by the manager, but they told us that the

Requires Improvement

Is the service well-led?

feedback would be developed into an action plan which would be shared with relatives and the staff team and actions would be taken to achieve any areas where improvement could be made.

Staff meetings took place periodically. There was evidence that issues were discussed with staff such as developments within the service and how staff might enhance the care people received. For example, staff were reminded not to outpace people when supporting them to eat and drink and importance of encouraging fluids. The registered manager also held specific meetings with the registered nurses which helped the manager to maintain an oversight of the clinical care within the home. Staff told us that they felt able to make comments or suggestions about how the service might improve. They felt that these were acted upon. One staff member said, "They [the registered manager] always listen to what I say, they are approachable and easily available".

Staff told us the registered manager promoted a positive culture within the home. They said morale amongst the staff team was good. A staff member said, "I love working here because the team, manager downwards, are great and the people too, it's a great place to work". Another staff member said, "The manager is always walking around, up and down to see what is going on, she talks to us and thanks us, which is great, she also knows relatives and residents well too which counts for a lot". A social care professional told us, "Home Park has a lovely homely feel….The manager is very knowledgeable about dementia care, supportive and appears to lead her staff well".

The registered manager told us that they were proud of the care provided by the home which was underpinned by the values of openness and the inclusion of people and their families. They felt that the care records had really improved and were more detailed and person centred than previously. They were also proud of the ongoing programme of redecoration which would improve the facilities offered to people living at the home. They acknowledged that the on-going challenges such as those relating to the deprivation of Liberty safeguards alongside the day to day demands of running the service. They felt however that they had good support from the provider who they said listened to their concerns and visited regularly so was aware of the matters affecting and relating to the running of the home.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person had not made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (1) (a)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person had not taken steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service users' needs and ensure the welfare and safety of the service user.** **Regulation 9 (b) (i) (ii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse.** **Regulation 11 (1) (b)** **The registered person did not have suitable arrangements in place to protect service users against the risk of any form of control or restraint being unlawful or excessive.** **Regulation 11 (2) (a) (b)**

This section is primarily information for the provider

Action we have told the provider to take

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person had not ensured the maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity and equipment and reusable devices used for the purpose of carrying on the regulated activity. Regulation 12 (c) (i) (ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity and in order to safeguard the health, safety and welfare of service users. Regulation 22

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person had not ensured that service users, and others who may be at risk, were protected against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity and identify and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This section is primarily information for the provider

Action we have told the provider to take

Regulation 10 (1) (a) (b)

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 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person had not ensured that service users were protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13