Park House Care (Sandy) Limited

Park House Nursing Care Centre

Inspection report

Mill Lane
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Bedfordshire
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out 29 April 2016 and was unannounced. During our last inspection in April 2014 we found that the service met the legal requirements in the areas we looked at.

Park House Nursing Centre is registered with the Care Quality Commission to provide care and accommodation for up to 30 people. Some people may require nursing care and people living at the home may have dementia. At the time of our inspection there were 28 people living at the home.

The home had a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People received their medicines as they had been prescribed. An electronic system had been introduced with the aim of improving medicines administration. However the system required further development to enable it to address all situations that could occur in the administration of people's medicines. During this inspection we Identified that there were some inconsistencies in the stocks of medicines held. Following our inspection the registered manager identified that these were down to errors within the system and introduced manual checks of medicines to identify and resolve any discrepancy speedily.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were enough skilled, qualified staff to provide for people's needs. The necessary recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They received training to ensure that they had the necessary skills to care for and support the people who lived at the home and were supported by way of supervisions and appraisals.

People's needs had been assessed before they moved into the home and they had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had a variety of nutritious food and drink available to them. There were freshly made, home cooked meals from a menu that had been devised using people's likes and dislikes. The cook made regular checks that people were happy with the meals and choices provided. Snacks and fruit were available to people

throughout the day.

Staff were kind and caring and protected people's dignity. Staff treated people with respect and supported people in a way that allowed them to be as independent as possible.

There was an effective complaints system in place. Information was available to people about how they could make a complaint should they need to and the services provided at the home. People were assisted to access other healthcare professionals to maintain their health and well-being.

People and staff were encouraged to attend meetings with the registered manager at which they could discuss aspects of the service and care delivery. People were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place and the provider was an active participant in the day to day running of 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?

Good

The service was safe.

People's medicines were administered in a safe way but due to limitations of the electronic system in use the stocks of medicines held were not always as the system indicated.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Good

The service was responsive.

People were supported to follow their interests and hobbies.

There was an effective complaints policy in place.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

The registered manager and the provider were visible and approachable. The provider visited the service regularly and was involved in the day to day running of it.

There was an effective quality assurance system in place.

Park House Nursing Care Centre

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 29 April 2016 and was unannounced. The inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with seven people, one relative and two friends of people who lived at the home. We also spoke with a nurse, two care workers, a cook, the registered manager and the provider.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for three people. We also looked at how people's medicines were managed and the ways in which complaints were handled.

We looked at two staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Good

Is the service safe?

Our findings

People we spoke to told us they felt safe living at the home. One person said, "The atmosphere here makes me feel safe." Another person told us, "I feel safe. There are no problems. I am not afraid or anything." A third person said, "I feel safe here. There is always people about and I have a press thing by the bed at night." A relative who visited the home regularly told us, "[Name] is safe. The care and attention he receives makes him safe."

The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm but would also be used to ensure that the building was properly evacuated in the event of an emergency.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. One member of staff told us, "We can go to [registered manager] and she will listen. If there is conflict she will listen to both parties. I have not had to use it." Information about safeguarding people was displayed within the home. Staff told us that they had been trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "In the first instance I would go to the manager but if I felt they were not doing anything I can call the safeguarding team [at the local authority]. In the staffroom there is a big poster with the number. We can always contact Care Quality Commission (CQC) too." Another member of staff told us that they would, "Look for changes in people's moods or behaviours. I would check for bruises and if they lost a lot of weight it could be caused by neglect."

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with the loss of sight, having a catheter and the use of bedrails. We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of both of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and by talking about people's experiences, moods and behaviour at shift handovers. This gave staff up to date information and enabled them to reduce the risk of harm occurring. One nurse told us, "We share risks at handover. The senior carers make sure they know exactly what the risks are and share them with the carers. If something is very serious then I make sure everybody knows myself."

The registered manager had carried out annual assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the handling of potential hazardous substances. Window openings and fastenings were inspected by the registered manager every month. In addition risk assessments were carried out for any fetes or charity events held. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained

within it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Accidents and incidents were reported to the registered manager. We saw that they kept a record of all incidents, and where required, people's care plans and risk assessments had been updated. The records were reviewed by the registered manager to identify any possible trends to enable appropriate action to reduce the risk of an accident or incident re-occurring to be taken.

People told us there were enough staff to support people effectively at all times. One relative told us, "There is enough staff. There is always someone around." People told us that when they used their call bell to request assistance staff responded quickly which would indicate that there were enough staff to support people appropriately. One person said, "They come quickly enough."

The registered manager told us that there were four care staff and the team leader on duty during the day and explained that staffing levels had been determined based on the level of dependency of the people who lived at the home. They told us that there was always one nurse on duty but most weekdays there were two during the day as well as a minimum of six care staff. In addition there was a cook and kitchen assistant, a maintenance person, housekeeping staff and an activities coordinator who worked 20 hours a week. A recently recruited care worker also worked part time to support people with their activities. Staff told us that they believed that there were enough staff to provide effectively for people's needs. During our inspection there was a visible staff presence in all the communal areas.

We looked at the recruitment documentation for two members of staff who had recently started work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

All medicines at the home were administered by trained nurses. People told us that they received their medicines when they were due. One person told us, "I have tablets in the morning. They come early in the morning to give me my tablets."

In the provider information return the provider had explained that they had introduced an electronic medicines management system and had amended their medicines administration policy and procedures to reflect the introduction of the system in November 2015. A nurse showed us how this worked and how it prevented nurses from giving medicines that had been prescribed as 'when needed' (PRN) at too frequent intervals. The electronic system had links to the GP system and pharmacy systems and had been designed to maintain a record of the stocks of medicines held. However, when we carried out a reconciliation of the medicines held for two people we found that there were discrepancies with the stock held and that recorded on the system. We discussed these with the registered manager who carried out an investigation into the causes of these discrepancies. During this investigation they identified a failing within the system if the GP did not update their system when a prescription for a medicine had changed. The electronic system also made no provision for damaged or destroyed medicines to be recorded. The registered manager discussed these failings with the pharmacy and the provider of the system to ascertain possible solutions to these problems. They have introduced a manual check of the stocks of medicines to be made by the nursing staff which would enable them to identify any discrepancy at an early date. This would enable investigation as to the cause of any discrepancy to be made more easily. The registered manager said staff should not have relied completely on the system; it was meant to be there to help, not to be a substitute for best practice, vigilance and accountability.

We saw that medicines were stored securely in locked trollies with a dedicated locked room for stock supplies. Controlled drugs were stored in a safe within a locked cabinet in the medicines storage room. We reviewed the controlled drugs record and saw that this had been correctly completed with each administration of the medicines having been witnessed by another nurse or a senior care worker.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the skills that were required to care for them. One person said, "I am sure they know what they are doing." When asked if they thought that the staff were well trained and knew what they were doing one relative commented, "They are well trained. I never see anyone 'flapping'." They went on to say, "I am very, very happy with the care. There is no downside; no fault. They are very attentive and I would definitely recommend it."

Staff told us that they received a full induction when they started working at the home and there was a programme in place which included the training they required for their roles. One member of staff told us, "I spent about two weeks shadowing [watching more experienced staff] and had a three page induction form to complete which detailed my learning and understanding. I am doing the Care Certificate self-assessment. I have three months to complete it." Another member of staff said, "My induction was about two weeks. I did some training such as moving and handling. I shadowed a senior care worker. They talked through the things I had to do and how to do them. The senior showed me how to use the hoist and slide sheets."

They went on to tell us of the on-going training that they received and that they felt supported by regular supervision. They said "I can discuss anything and everything during supervision. I am up to date with all my training. We have a lady that comes in when we are due a training course. We don't have e-learning. I have done a few additional courses such as end of life care and dementia." They went on to describe the impact of the training they had received on dementia. "It made me think differently about people. It made me a bit more understanding. I just have to be there for them as best as I can." They also told us that they had been supported to gain recognised qualifications. "I have got NVQ levels two and three whilst I have been here. I want to do level five and the manager will support me and is looking into this." This showed that staff were supported to develop their skills to improve their effectiveness in their roles.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. 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 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 looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that, where applicable, assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest.

People told us that staff asked for permission before they supported them. One person told us, "They ask

before they do things and talk to you whilst they are helping you." We observed staff ask people before they provided care or support to them. Staff told us that they always asked for people's consent before providing any care or support. One member of staff told us, "I always ask people. For example if I am going to give someone a shave I ask if they want to use an electric razor or a wet one. If they say no they don't want one then I won't give them a shave. I would try to persuade them and given them all the reasons why they should have the support. If they have not got capacity I might have to spend more time persuading them to agree. If refusal would affect their health then I would have to look at best interests." People were also able to make choices. One person told us, "They arrange for me to have a bath or shower. When I want one, they arrange it. My clothes are all hanging in the wardrobe and they sort me out with what I want to wear. They sort it out so it's nice."

Staff explained how they communicated with people. One member of staff said, "I use lots of methods to communicate with people who can't speak to us, eye contact, and body-language or, picture cards. [Name] has a box from the speech and language therapist. They press T and it says 'toilet', d and it says 'drink' so we know what they want." This meant that people were able to express their views and make their own choices.

People told us that they had a good variety of nutritious food and drink. One person told us, "I get as much as I want to eat. I am never hungry." Another person told us, "You can have what you want for breakfast, chocolate porridge, bacon sandwich, fried eggs, anything. If they have not got anything if you ask they will rustle it up for you. If you ask for something if they have got it they will give it to you." A relative described the food as, "Fantastic."

We observed the lunch time experience for people who lived at the home. The tables were nicely presented and people were asked what meal they would prefer. They were offered a choice of wine or drinks with their meal. People's care plans indicated whether they were likely to require assistance or encouragement to eat their meal. The cook came to the tables and asked people as they were eating whether they were enjoying the food. We saw that people had been offered alternatives to the fish dishes on offer at lunch and some people had chosen to have egg and chips instead.

We spoke with the cook. They had started work at the home about a year ago and had discussed what people liked to eat when they planned the menus. They had a good knowledge of people's likes and dislikes, which had been clear when they spoke with people during the lunchtime meal. The cook told us that all food was prepared freshly on site, including all the cakes and desserts. This was more cost-effective for the service as well as giving people foods that they preferred. They told us that there were currently no people who had any allergies or special dietary requirements living at the home. However, if anyone did require any special diets these would be catered for. People who had diabetes were served smaller portions of the meals offered to everyone. Fresh fruit was available to people throughout the day. People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake that provided detailed information on what they had consumed. Where needed, referrals had been made to the local dietetic service and the speech and language therapists.

One healthcare professional we spoke with during the inspection was very positive about the responsiveness of the service in contacting them if there were any concerns about a person's health or well-being. They told us that the staff were really knowledgeable about people, accompanied them and told them about the person when they visited the service. They described the service as, "Fantastic" and said it was one of the best, with staff going over and above what was in the best interests of the patient.

Records showed that people were supported to attend appointments with other healthcare professionals,

such as dentists, opticians and chiropodists, to maintain their health and well-being.

Good

Is the service caring?

Our findings

People and the relatives we spoke with told us that the staff were kind and considerate. One person told us, "The people [staff] are nice. Well they couldn't be bad…look at all these people here." Another person told us, "I am happy living here." A relative said, "The care is fantastic. They can't do enough for [Name]." They went on to say, "In general the staff are all so friendly. It is a real home from home."

Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives, and from the lifestyle profiles within people's care records. Lifestyle profiles had been developed in discussion with the people and their relatives to give as full a picture of the person as possible. One member of staff told us, "We are quite open and are close to the residents. They are happy to talk to us."

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. One relative told us, "They have the patience of a saint." In the most recent satisfaction survey completed by people and their relatives one comment said that the respondent welcomed, "The kindness and efficiency of the mostly youthful staff." Another respondent commented that, "Everyone is very friendly, helpful and polite." We saw that staff communicated appropriately with people. They spoke with them in a gentle and caring way as they passed through the communal areas and as they supported them with care and activities.

People told us that the staff protected their dignity and treated them with respect. One person told us, "If I am in my bedroom staff knock on the door before they come in." A relative told us that their relative was well groomed, well presented and that their bedroom was always clean and tidy. One member of staff told us, "We care about the welfare of the people here. We give them person-centred care and make sure they are safe and well cared for. We respect their dignity and privacy." They were able to describe ways in which people's dignity was preserved. For example asking quietly if they require personal care in communal areas, ensuring that doors and curtains were closed when providing personal care and covering people when helping them to wash. Staff explained that all information held about people was confidential and would not be discussed outside of the home to protect people's privacy.

People told us that they were encouraged to be as independent as possible. One person told us, "I do whatever I want to do here. I am quite happy." People, visitors and relatives told us they were free to visit the home at any time. One person said, "I get my family come to visit me quite often." Another person said, "My [relative] sometimes comes and a friend pops in when they can. They can come at any time. They don't have to ring up." A visitor told us, "The staff are always very welcoming." Meanwhile, a relative, who was complimentary about the service, said, "I can come at any time. I never find it any different." People were supported to maintain relationships with friends and family. Wi-Fi access was available throughout the home so that people could have visual contact with friends and relatives at any time. Additionally visitors were able to share photographs and videos with people more easily.

Information was displayed on notices in the hallway for people and visitors. This included information about safeguarding, the complaints system, fire evacuation instructions and details about planned activities for the month. This meant that people, their friends and relatives had the information that they needed and could plan how they wanted to spend their time.

Good

Is the service responsive?

Our findings

Our findings
People and their relatives told us that they had been involved in deciding what care they were to receive and how this was to be given. Before people joined the service the registered manager had visited them to assess their needs and whether the service was able to fully meet them. On the day of the inspection the registered manager went to assess the needs of a person who had enquired about moving into the home.

People and their relatives told us that the care they received reflected their individual needs. The care plans followed a standard template which included information on people's personal history, their individual preferences and their interests. Each was individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. One care record included plans that covered the individuals' loss of sight, their low moods and their mobility. Another care record had care plans to manage the person's catheter, diabetes and warfarin.

People told us that they or their relative were involved in the regular review of their care needs. One person told us, "I have a care plan but don't see it. My [relative] deals with all of it. [They] come about once a week." Staff told us that care plans were reviewed by the nursing staff on a monthly basis or more often if this was appropriate due to changes in people's physical or mental health. The care records that we looked at showed that care plans had been reviewed each month. However, we had noted during discussions with the registered manager that one individual had for some weeks chosen not to get out of bed. Although other care plans within their care record reflected this the plan for management of their mobility had not been updated. The registered manager told us that this would be amended to reflect the current situation. We noted that the daily records of people's lives did not reflect what they had done. Entries were brief, such as 'had a peaceful day'. We brought this to the registered manager's attention who agreed that fuller descriptions were necessary. They said that they would discuss this at the next scheduled staff meeting. We saw evidence that relatives were kept informed of any changes to a person's health or well-being.

People told us that that took part in various activities. One person said, "I have a scooter to go out in. I go out to the shops and to [a local pub]." Another person told us, "I go out, just the odd time. I just walk around locally. I went to the pub once or twice." However, another person said, "I don't really do a lot of things. I don't knit or anything. I used to but I just don't want to do it now. I am happy just watching television or reading or whatever." During the lunchtime period one person told us that the flower decorations on the table and around the home had been made by someone who lived at the home. The person who had made the decorations told us that the staff were very supportive of this activity, which was shared with other people who lived there. We observed members of staff throughout the day assisting people in various activities on a one to one basis. One member of staff was playing word games with one person. Another member of staff was talking to someone about the newspaper they were reading. This showed that people were supported to maintain their interests. During the afternoon one of the members of the care staff ran a bingo session and later in the evening they put on a film show. The registered manager told us that they had an activities coordinator who worked for 20 hours a week and one of the care staff was also employed on a part time basis to provide additional activities. There was a schedule of planned activities available in the

entrance hall so people and their relatives could plan their time. There were photographs of people taking part in activities on a noticeboard by the activity timetable.

There was an effective complaints policy in place. Although the people we spoke with were aware of the complaints system they said that they had no cause to use it. One person told us, "I am happy I have no complaints." A relative told us, "I have got nothing to complain about. If I feel there is anything wrong I can speak with [Registered manager]."

Good

Is the service well-led?

Our findings

People and staff had confidence in the registered manager and the provider. They found them to be open and approachable. One person said of the registered manager, "I see [registered manager]. She comes round to talk to you." A relative said, "I see [registered manager]. I only have to knock on the door. She always has time for you." One member of staff said of the registered manager, "She is brilliant. She is so good. She can be well firm if she needs to be but is there for any issue. I couldn't ask for a better manager." Another member of staff said of the provider, "He is one of the nicest men I have ever met. He has your back and will always support you. If things need sorting he is really good."

People were asked their opinion of the service that was provided and for ways in which this could be improved by way of an annual satisfaction survey. The last survey had been completed in December 2015 and the feedback from this had been positive.

In addition to the questionnaires the provider held meetings with people and their relatives at which they were able to discuss the operation of the home and ways in which the service provided could be improved. Minutes of the meetings showed that topics people had discussed included activities, food, staff and the refurbishment plans. People and residents were asked for their suggestions as to how the home could be refurbished to provide an environment that would allow people to move about the home more easily. These opportunities allowed people and their relatives to contribute to the development of the service

Staff were also able to contribute to the development of the service during supervisions and staff meetings. One member of staff told us, "We can come up with ideas on how things can be improved. We try things out. I made a suggestion about staffing on the three sections and we tried doing it in different ways." Minutes of a staff meeting held in November 2015 showed that topics discussed had included the communication, allocation and people's bed times. Minutes of a monthly senior team meeting held in March 2016 showed that the senior staff team had discussed working relationships between the nursing staff and the senior care staff and their respective knowledge of the people who lived at the home. The purpose of these discussions had been to improve the care and support provided to people. Staff told us that they were supported by regular reviews of their competency. They were knowledgeable about their roles and what was expected of them.

There was an effective quality assurance system in place. Quality audits completed by the registered manager covered a range of areas, including a monthly audit of care plans, infection control and accident and incident management. Action plans had been developed where shortfalls had been identified and the actions were signed off when they had been completed. The provider visited the home regularly and carried out regular 'walkabouts' to inform themselves of the standard of care provided and any improvements that were needed.

We saw that there were robust arrangements for the management and storage of data and documents. People's written records were stored securely and data was password protected and could be accessed only by authorised staff.