Cumbria County Council

Parkside

Inspection report

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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

Care service description:

Parkside is a residential care home that can provide personal care and accommodation for up to 31 people across three units. Each unit had separate adapted facilities and all bedrooms were for single use. The majority had wash-hand basin with a few having ensuite facilities. Bathrooms were adapted for use of people with limited mobility. The majority of people had support needs associated with old age. Two of the units specialised in providing care to people living with dementia. There were 23 people living in the home when we inspected.

People's experience of using this service:

People continued to receive a consistently good service and felt safe with the support they received from the staff. One person told us, "I've never had any worries at all, and I trust the staff completely. The support I get is first rate."

People's individual needs and preferences were known and understood by staff which meant that they received a person-centred service. Staff knew people well and were in sufficient numbers to make sure people received safe care that also promoted their independence.

Staff were caring and treated people with dignity and respect and ensured people's privacy was maintained particularly when being supported with their personal care needs.

People received their medicines safely and medicines that were prescribed on an 'as required' basis were given safely. Support was provided which ensured people received food and drink when they needed this.

Healthcare professionals praised the staff team's diligence in monitoring people's healthcare and working together in partnership with them to promote people's health and well-being.

A stable staff team had the skills and knowledge to meet people's needs. There was a rigorous programme of training and staff supervision that made sure staff were up to date with the latest guidance and were competent to carry out their roles.

People were supported to be involved in decisions about their care and staff sought appropriate consent and asked people what help they needed. People and staff felt they were listened to and that their ideas and any concerns they may have were addressed.

The service was well-led by a dedicated management team who demonstrated compassion and commitment to the needs of the people living in the home, as well as the staff who worked for them. The provider had well-developed auditing systems in place to check the quality of the service.

More information is in the Detailed Findings below.

Rating at last inspection: Good (4 August 2016).

Why we inspected: We inspected the service as part of our inspection schedule methodology for 'Good' rated services.

Follow up: We will continue to monitor as part of the re-inspection programme for a Good service. If any concerning information is received we may inspect sooner.

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 remains Good.

Details are in our Safe findings below.

Is the service effective?

Good

The service remains Good.

Details are in our Effective findings below.

Is the service caring?

Good

This service remains caring.

Details are in our Caring findings below.

Is the service responsive?

Good

This service remains responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

This service remains well-led.

Details are in our Well-led findings below.

Parkside

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.

Inspection team: One inspector and an expert by experience conducted the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

Service and service type: Parkside is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This service did not provide nursing care.

The service had a manager registered with the Care Quality Commission. This means they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: This inspection was unannounced.

What we did when preparing for and carrying out this inspection:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse; and we sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection, we spoke with 15 people who used the service and five relatives to ask about their experience of the care provided. We spent most of our time talking to people who lived in the home, observing how they spent their time and how staff interacted with them.

We spoke with eight members of staff including the registered manager, shift supervisor, cook, domestics

and care workers. We reviewed a range of records. This included six people's care records, medication records, six staff files and records relating to the management of the home. In addition, we spoke with a visiting district nurse during the inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk: safety monitoring and management; using medicines safely; preventing and controlling infection:
• Risks to people were assessed and managed safely. There were detailed, up to date records that showed which risks were assessed. These included environmental risks, medication management and risk of falls. Staff were given clear guidance on the prevention of risk that was based on good practice guidelines such as National Institute for Clinical Excellence (NICE) Falls Prevention.
• Staff received training which ensured the safe use of equipment. This included the use of specialist equipment to support people with complex healthcare needs, such as hoists and profiling beds.
• Emergency procedures for keeping people, staff and others safe were in place and they were regularly reviewed and updated as required. These included personal emergency evacuation plans (PEEPs) and a business continuity plan.
• People living in the home told us that staff always wore these when carrying out personal care that the home was always very clean and pleasant smelling. Staff were trained to follow good infection control practices; used personal protective equipment (PPE); and had rigorous cleaning schedules to help prevent the spread of healthcare related infections.
• People told us they were very happy with how the home managed their medicines. The home had robust systems in place that supported the safe administration of medicines. This included: staff training; regularly checks of staff competency; and up-to-date policies and procedures to support staff practice. Medicines were managed in accordance with current guidance and medicines records were regularly audited by the registered manager and senior staff. There were also procedures for updating how 'as and when' medicines were given and how they were recorded. Appropriate storage and security was in place.

Systems and processes to safeguard people from the risk of abuse:
• People told us they felt very safe in the home and were comfortable with the staff who supported them. One person told us, "I have no worries about this place. I can speak to any of the staff, they're all easy to get on with."
• People had a safeguarding guide with contact numbers within a brochure kept in each person's room. Relatives were confident that staff would act to keep people safe. One told us, "The staff are very professional and well-trained. I'm completely satisfied that my [relative] is safe here. I've never witnessed anything of concern."
• Staff in the home were aware of their responsibilities in protecting people from harm or abuse as they had received regular training and guidance was in place about making safeguarding referrals. These adhered to the local authority safeguarding protocols and appropriate referrals had been made so that allegations could be independently investigated in line with these protocols.

Staffing and recruitment:

• People and their relatives told us that there were always enough staff on duty. One person told us, "There's always staff to hand." Another person said, "They are quick to come if I push my buzzer. I never have to wait long at all." Call bells were placed near to hand and answered quickly when pressed. There had been a stable staff team for many years. People told us that this was reassuring as staff knew them well and this had allowed a trusted relationship to grow.
• Staffing levels were sufficient to provide safe and individual care to people. The registered manager made sure that extra staff were available if someone was unwell or at the end of their life so that all their needs could be met.
• Safe staff recruitment practices were in place to make sure staff were suitable to work with vulnerable people. The service checked for any gaps in staff employment history and reasons for leaving the last job. All new staff had a Disclosure and Barring Service (DBS) check prior to applicants being offered a job. There was also a three-month probationary period to further check that they were suitable for the role.

Learning lessons when things go wrong:
• The registered manager and provider had rigorous systems in place to monitor risk in the home; identifying any patterns and taking action as a result.
• There was a robust learning culture within the home and across the providers' other services. Falls, accident and incidents were recorded and analysed to identify trends and patterns and ways of reducing risks, this also included medicines errors. One such measure had been to target medication errors across all services with a series of measures put in place, including policy and procedure updates and refresher training. Medication errors were significantly reduced and were now very rare. There had been none in the home in the last 12 months.
• Lessons from incidents across the organisation and outside the service had been shared with all services run by the provider. This was an example of best practice which showed this was a learning organisation.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with guidance standards and the law; supporting people to live healthier lives, access healthcare services and support; staff providing consistent, effective, timely care within and across organisations:

• People's heath and care needs were very well assessed to determine that the home was suitable and that staff had the skills to meet their needs. The information gathered included people's preferences, backgrounds, personal histories and any cultural needs. This enabled staff to know people well and provide person-centred care.
• Effective systems were in place to monitor any changes to people's health. Within the records we saw that the registered manager had introduced a colour coded system to alert staff to changes; and for them to use this system to alert senior staff so that action could be quickly taken. This ensured that instructions and advice given by external healthcare professionals were written up and actioned by staff.
• People received timely support to access healthcare services and professionals when they needed help. Information was shared with other agencies if people needed to access other services such as hospitals. The use of 'hospital passports' with key information helped to ensure people's care and support needs were met and the support given was consistent.
• One person told us, "The staff are good at spotting when I'm under the weather and will call the doctor if I need one. The district nurse regularly sees me to dress my legs. Then the staff put the creams on and I have to rest in the afternoon and put my feet up to ease them. It's good team work and my legs are improving."
• The staff team had good working relationships with the local health and social care teams in the area. One visiting professional told us, "The team here are great to work with, always on the ball. They have learnt from our input and get in touch quickly when they need to. We have an agreement with the local authority [provider] to have a community nurses' office base here at night. So, we get to see what's going on at all times of the day and the care here is very good."

Staff skills, knowledge and experience; ensuring consent to care and treatment in line with law and guidance:
• People felt staff were competent to give them the care they needed, and that staff were flexible with the support they provided. A relative told us, "The staff are defiantly well-trained. I'm very impressed with their knowledge."
• The service's training matrix showed that staff completed a wide range training courses including dementia care, medicines management, health and safety, moving and handling, the Mental Capacity Act 2005, and equality and diversity.
• Staff were regularly observed in practice by senior staff and received supervision with their line manager. New staff completed an induction programme that followed the care certificate. The care certificate is a

nationally recognised set of standards which provides new staff with the expected level of knowledge to be able to do their jobs well.

Supporting people to eat and drink enough to maintain a balanced diet:
• People told us they were very satisfied with the quality of the food provided, and especially liked that it was home-cooked with plenty of home-baking of cakes and puddings.
• People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss and action taken. Referrals were made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance.
• The cook had training in providing good nutrition to older people and knew how to fortify foods for people who had lost weight, and was knowledgably of specialist dietary needs, such as food suitable for people with diabetes.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

• We found that the service was working in-line with the principles of the MCA. Staff had a good understanding of the MCA and gave appropriate support so that people could make decisions for themselves. Where people's capacity to make decisions was compromised for example by a health condition, such as people living with dementia, then the home followed the MCA to ensure their rights were prompted and protected.
• Staff ensured they had people's consent before carrying out care tasks, and this was recorded in people's files. Some people had restrictions placed on them to keep them safe such as: the use of bed rails; monitoring movement by sensor mats to prevent falls; and digital keypad on some doors. The service checked these restrictions and consider them as part of a best interest process as set out by the MCA and appropriate referrals had been made to the local DoLS assessing body.

Adapting service, design, decoration to meet people's needs:
• Parkside was a purpose-built property built in the 1960s and some of the provision was now out-dated. This was particularly the case in the size of the bedrooms, some of which were very small and did not have ensuite facilities. However, the home had continued to be adapted for its current use over the years. This included ensuring bathrooms were adapted for people with limited mobility and dividing the home into smaller, more homely units with individual kitchens and dining areas.
• The home had given careful consideration and effort into providing a home that was adapted for people living with dementia. The garden had been re-designed so that people who had poor mobility and so that those living with dementia could enjoy the outside space. Clear signage was used throughout the home and one of the units for people living with dementia had a reconstruction of a 1950s sitting room.
• Technology and equipment was used effectively to meet people's care and support needs. For example, sensor alarms helped to keep people safe and a call bell system was in place. People did not have access to laptops or computers, unless they made use of their own phones. The registered manager said they would consider how they could develop this within the home.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity:
• People told us staff treated them with kindness, respect and compassion and made many positive comments about their caring nature. Comments from people included, "I don't think they could possibly do any more to show how much they care." Another person said, "I'm treated so well it's like a hotel on Park Avenue."
• People said care staff knew their likes and dislikes and always found the time to talk with them. They described the support they were given as "unhurried" and "not rushed". We observed very caring and compassionate support with staff using touch to convey warmth and empathy. We saw staff respond to one person who was agitated by holding their hand and put an arm round their shoulder; they were offered choices and took a seat where staff read a magazine with them.
• Keyworkers were linked to individual people so that relationships were encouraged and this staff member chose the present specifically for that person. The service being based within the local community meant that staff and people in the home had a lot in common, including friends, relatives and this lead to lots of chats and meaningful conversations. One person told us, "When one of us gets a visit from a relative we all get one, that's what it's like in here. We all know each other, it's lovely to be able to stay in touch."
• Staff had received training in equality and diversity and on person-centred care. This was reflected in how they supported and treated people with dignity and respect. The written care records were worded in a respectful way and no inappropriate or demining language was used.

Supporting people to express their views and be involved in making decisions about their care:
• Staff understood how best to communicate with people, for example, speaking slowly and clearly. Care records reflect how best to support someone with a sensory impairment.
• The amount of information contained in care records demonstrated the views of people using the service and their family members had been sought. Information about people's background, history, favourite past times and life experiences had been captured in care records.
• Easy-read information was displayed, such as posters about how to report complaints or safeguarding concerns or gain advocacy services.

Respecting and promoting people's privacy, dignity and independence:
• People who used the service were treated with dignity and respect.
• The service was very aware of how to handle confidential information. This was being stored securely and in line with The General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals.
• Staff promoted people's independence and encouraged them to do things for themselves. People told us they were sensitively encouraged to do things for themselves and this helped to boost their confidence and

self-esteem.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that that the service met people's needs

People's needs were met through good organisation and delivery.

Personalised care; accessible information; choices, preferences and relationships:
• People were receiving care and support that was person-centred and responsive to their needs. People's routines were flexible and people were making choices on a routine basis for example, whether to have a lie-in or to eat their meals where they chose. One person said, "We do as we please here." Another person told us that there was lots to do if you wanted.
• Care plans were developed with the person and reflected people's choices, wishes and preferences and things that were important to them. This included detailed life stories, lifestyle choices, social interests and likes and dislikes. The plans contained in-depth information about people's assessed support needs and any health needs. This supported staff to care for people in the ways and manner they wished.
• People's needs, including those related to protected characteristics, were identified. We saw details around equality and diversity were included in care plans and staff had received training in equality and diversity. People's spiritual needs were being well met by the home and were recorded in their files.
• People were able to participate in a variety of activities which included opportunities to access the community. One person said, "I can go to so much if I wanted: chair aerobics, bingo, singalongs, coffee afternoons, dominoes, reminiscence sessions, out to cafes and days trips out.
• Staff gave people support to peruse their individual interests and hobbies. Staff went out of their way to ensure people could still follow interests. One person had been helped to keep hens in the grounds of the home, and carry on with an allotment. They told us, "I put potatoes in that raised bed and I grow onions in the l 'al one." Another person was making items and gifts out of leather and selling them for the homes' amenity fund and local charities. Staff had helped them source materials.

End of life care and support:
• People were asked about where and how they would like to be cared for when they reached the end of their life and this was recorded in their care plan. This captured their views about resuscitation, the withdrawal of treatment and details of funeral arrangements. It gave people the opportunity to let other family members and professionals know what was important for them in the future, when they may no longer be able to express their views.
• The service worked closely with healthcare professional to ensure that people had a pain free and dignified death.
• One relative told us, "The home has asked us all about what my [relative] wants near the end and this was a difficult conversation but [relative] was glad to have had the chance to say while she can."

Improving care quality in response to complaints or concerns:
● People said they knew how to complain or raise any concerns that any problems were "sorted out straight away."
• The complaints procedure was on display in the entrance to the home. People also had a copy of the

complaints procedure that was available in the contract they signed when they moved into the home. A record of complaints was maintained and we saw the most recent one had been investigated and resolved appropriately and to the person satisfaction.

• There were no ongoing complaints that had been received in the service.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that the service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support with openness; understanding and acting on their duty of candour responsibility; managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• The home was being very well-led by an experienced and skilled registered manager who had created and promoted high-quality, person-centred care.
• The culture of the service was open and friendly. Staff understood their responsibilities and felt they were listened to and valued.
• The manager used the systems of the organisation to monitor the quality of the service and in addition she had also devised her own systems. One of these additional measures was coloured coded risk assessments with the actions needed to take to meet people's needs.
• The registered manager and staff we spoke to understand the importance of escalating change in people's health and social needs and this showed that the provider had embedded principles of duty of candour responsibilities. Staff were clear that they had to act when people's needs changed.
• The service continued to use robust quality assurance tools which showed lessons learnt and areas of service provision identified for improvement. Quality checks undertaken by the registered manager cross referenced to Care Quality Commissions regulatory requirements and key lines of enquiry. This helped maintain a safe and well-run service.
• The service also ensured that national good practice was followed such as NICE and Skills for Care as resources for staff to use.
• All staff we spoke with demonstrated a desire to provide quality care for people using the service. There was consistent positive feedback about the manager and senior support staff. These included; "The manager is really approachable and is always fair." And "All senior staff very good in supporting us. They led by example."

Engaging and involving people using the service, the public and staff fully considering their equality characteristics; working in partnership with others:
• People and staff felt able to share ideas or concerns with the management. Surveys were given to people who used the service and their family members. The results of these surveys were analysed and action plans developed. The registered manager had ensured the surveys were as independent as possible by using staff from another service to assist people completing the surveys. Results showed a high satisfaction with the quality of the service delivered.
• The service had a compliments file in place which contained numerous positive comments from people who used the service and their family members about the service and staff members.

• The provider worked professionally with external agencies such as social services and the health authority. One such partnership was the community nurse having an office base in the home. This had improved working relationships and the service offered to people in the home. Staff said it was helpful to have them on site.
• We saw evidence that demonstrated the service consistently worked in partnership with the wider professional team. Care records included the involvement of GPs, social and healthcare professionals and advocates for people they supported.
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Continuous learning and improving care:
• A variety of regular audits and quality monitoring was taking place. Findings were recorded and included the actions taken to improve the service. These included medicines audits, care plan audits, spot checks. This was an organisational wide learning exercise on accident and any significant events.
• There was a strong emphasis on sharing best practice within the service and within the providers' other services. We could see that this had assisted in the maintaining standards and timely identification of any shortfalls. Staff meetings were held bi-monthly. They all said they had good communication between the staff team.
• The provider held best practice meetings for various subjects which included; health and safety and workforce development. Staff attended steering groups within the organisation and fed learning back to the team for areas such as; changes made around the provision of care and the development of three new homes.