Care Quality Commission

Monarch Consultants Limited

Parkside Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

We inspected the service on 08 and 09 April 2015. Parkside Nursing Home is registered with the Care Quality Commission to provide accommodation for up to 50 older people with varying support needs including nursing and dementia care needs. On the day of our inspection there were 41 people living at the home.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

When we last inspected the service in February 2014 we found there were improvements needed in relation to staffing levels. The provider sent us an action plan on 15

Summary of findings

March 2014 telling us they would make these improvements by October 2014. We found at this inspection that improvements had been made. Staffing levels had been increased prior to the inspection.

At times people did not receive safe care because systems to guide staff on how to manage risks people may face were not followed or kept up to date. People were at risk of not having their medicines as required because the arrangements to manage these were deficient.

People told us they felt safe living at the home, but we found systems designed to keep people safe were not being followed.

Staff did not feel fully prepared for their work by the training they received. Staff were unclear about their role in protecting people's rights to make decisions for themselves or how to lawfully restrict someone's liberty.

There were arrangements in place to encourage people to eat and drink to ensure their nutritional and hydration needs were met, but these were not being followed. People were supported to have their healthcare needs met.

People did not experience a consistent level of kindness, privacy or dignity.

People had opportunities to take part in activities in the home and go on day trips. People's care and support was sometimes well provided for and at other times was poorly organised. People could not be assured they would be given choices they were able to make. Staff did not always have the direction they needed on how to meet people's needs.

People could raise any complaints or concerns and felt assured these could be listened to and considered.

Staff did not feel the management of the home provided them with the encouragement and support to carry out their responsibilities. Systems designed to monitor the quality of the service to help identify improvements had not been effective.

You can see what action we told the provider to take at the back of the full version of the 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?
The service was not safe.

Risks people faced were not properly assessed so people were not protected from avoidable harm. Medicines were not safely managed.

Procedures to protect people from harm or abuse were not followed.

There had not been sufficient staff on duty to meet people's needs. The number of staff had recently been increased to rectify this.

Requires improvement

Is the service effective?
The service was not effective.

Staff training did not ensure staff were suitably equipped to carry out their role.

People's rights under the Mental Capacity Act 2005 were not fully protected.

People did not receive the best encouragement and support to eat and drink well.

People received healthcare support when needed.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were not shown the same degree of kindness and compassion from all staff.

People may not have their privacy and dignity promoted.

Requires improvement

Is the service responsive?
The service was not always responsive.

People did not receive a consistent service so there were times when they did not have their needs met.

People could raise any complaints or concerns and knew these would be listened to.

Requires improvement

Is the service well-led?
The service was well not led.

There was a lack of trust and respect within the staff group.

People did not have the benefit of living in a home that was well managed.

Audits carried out by the provider had not identified issues of concern found during this inspection.

Requires improvement

Parkside Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and carried out over two days on 08 and 09 April 2015. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed the information we held about the service. This included previous inspection reports and action plans sent to us by the provider. We reviewed information from members of the public and health and social care professionals. We also reviewed statutory notifications. A notification is information about important events which the provider is required to send us by law.

During the inspection we spoke with four people who used the service, two care staff, an activities coordinator, two kitchen staff, a housekeeper, the training facilitator, the finance director and the operations manager who was a member of the provider's senior management team. We also spoke with six relatives of people who used the service.

We observed care and support in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at the care records of six people who used the service. We also looked at a range of records relating to the running of the service including audits and risk assessments.

Requires improvement

Is the service safe?

Our findings

We observed people did not always receive care and support in a safe way so they were put at risk whilst supported. We were told by one person who lived at that the home that they had fallen recently and four relatives told us their family members had fallen as well.

Staff were concerned about the arrangements for assessing risks people faced. This included a lack of expertise by staff with these responsibilities and the required documentation had not been completed. Staff said they had been told to ensure risk assessments were up to date but had not been given the time to enable them to do this. We observed two occasions where staff used unsafe moving and handling processes. A visiting healthcare professional also informed us they had seen unsafe moving and handling processes used.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a nurse administering medicines to some people and saw they did so discreetly and unrushed. The nurse explained to the person what the medicines were before administering them. However a staff member who was responsible for administering people their medicines said they did not feel proper provision of time was allowed for them to be able to do this safely, because of the other duties to complete during the shift. Some visiting healthcare professionals were also unhappy with medication arrangements and as a result of their concerns and findings they suspended contracts with the home.

We found a number of concerns over the arrangements in place for the safe supply, storage and administration of medicines. Records showed that there had been periods of time where people who used the service had been without prescribed medication for long periods of time. Visiting health professionals had raised concerns about this. We saw that medicine assessments were not done promptly when a person moved to the home. Medicines returned to the home when a person came out of hospital had not been effectively checked in.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection on 25 February 2014 we identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulations 2010) which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the systems in place did not enable the effective maintenance of staffing levels In order to safeguard the health, safety and welfare of people who used the service. At this inspection we found recent improvements had been made to staffing levels.

We saw some people who required a higher level of staff support were receiving this. For example a person who was at high risk of falls had a staff member with them when they were in their room. A person told us they thought, “More staff would be better.” Relatives told us there had been an increase in staffing levels recently.

Some healthcare professionals had raised concerns at the number of staff on duty when they visited the home. The operations manager agreed some staff who should have been working were not at the home. A staff member told us staff had been covering extra shifts and were becoming tired. A staff member described staff as being, “Burnt out.” We had also received other concerns about there not being enough staff on duty prior to this inspection using the ‘Share your experience form’ on our website.

A staff member told us staffing levels had been increased the previous week. They said this had “A positive effect”. Other staff said as a result of the recent staffing increase the last couple of days had been calmer and less rushed. The rota showed there had been an increase in staff on duty over the last few days. We saw staff files did not show all the correct recruitment checks had been followed.

There were keypads fitted to the front door and to some internal doors which enabled people to have freedom of movement in areas of the home where it was safe for them to do so. This included preventing people on the first floor having unaccompanied access to the staircase. One person told us how they liked to be able to access an area at the rear of the home where they were permitted to smoke. The person told us how they had fallen from a chair in this area and we saw this had been replaced with a more stable seating arrangement. One relative told us their family member was at risk of falls and staff had provided them with equipment to protect them from harm which allowed them to keep their independence with their mobility.

Requires improvement

Is the service safe?

We saw some broken drawers blocking an outside fire exit, which would have prevented someone from using the exit in an emergency We drew this to the attention of staff who removed these immediately.

We asked people if they felt safe at the home and they told us they did not have any concerns about that. We saw two people who used the service started to have a disagreement with each other and this was responded to promptly by a member of staff, who resolved the issue in dispute. However we found there were occasions where the provider had not taken the action required to ensure people were protected from harm or abuse by involving the local authority safeguarding team, or there had been a delay in doing so.

People could not be assured that they would be protected from harm or abuse. We found there had been incidents of tension between two people who used the service, but action had not been taken to manage the contact they had to avoid the tension occurring. The operations manager and ourselves observed one person was provided with inappropriate care by a member of staff, which resulted in a safeguarding referral being made.

Prior to our inspection we were aware there had been concerns raised about the safety of one person, however staff were unaware if the manager had made a referral to the local authority safeguarding team. One incident where a person sustained a significant injury was reported to the local authority safeguarding team by a visiting healthcare professional, but this had not been reported by anyone employed at the home.

Although staff we spoke with knew about safeguarding and how people should be protected from abuse or harm this knowledge had not been put into practice. One staff member told us they had previously raised a concern about someone's safety so they knew how to do so it they needed to. The staff member said they believed the required actions had been taken, but they had not been told if they had, so they did not know what had happened after they had raised their concerns. Support staff had also received training on safeguarding and told us they would be confident to recognise and report abuse.

Requires improvement

Is the service effective?

Our findings

A staff member told us the training they received to support them to do their work had not been very good but this was now improving, however they did not think it was to the standard they needed to enable them to work effectively. A staff member told us they had good support and training, but whist we were talking with staff they told us about essential training they had not received. This included managing challenging behaviour and assessing risks people may face.

We spoke with the training facilitator who told us they showed staff a DVD about a topic followed by a discussion afterwards. A staff member told us there was a new DVD to train staff on moving and handling. The training facilitator told us they had no plans to provide practical moving and handling training. This meant that staff would not have the opportunity to practice safe moving and handling techniques and be familiarised with the equipment used.

There was no training matrix in place to show what training staff had completed and what still needed to be done. This meant there was no oversight of what training each member of staff needed to equip them to carry out their role safely. The finance director told us that the provider had appointed a training manager to look at training and they will develop a matrix as a priority.

A staff member told us their training on the Mental Capacity Act 2005 had consisted of watching a DVD. The staff member said they had not understood the part about DoLS. We saw a record in one person's file stated the person was deciding where they wanted to live, however information in mental capacity assessments suggested the person would not have the capacity to make that decision. We also saw 'Do not attempt resuscitation' forms (DNAR) had not been completed correctly so people may not have their wishes respected.

People told us they enjoyed the food and it was of a good standard. A person who used the service told us, "I like the food. It was lovely today. It was different."

Several relatives said that their family members had reduced appetites but that a dietician had been involved and food supplements were provided to increase people's nutritional intake. A relative told us there were always plenty of fluids provided throughout the day to promote people's hydration. We saw hot drinks were provided at regular intervals throughout the day.

We were told there was a policy of protected mealtimes so people would be able to eat their meals without interruption which would encourage them to eat well. However we saw people's medicines were brought to the dining room and administered to them during the mealtime. We saw one person was given a tablet they had to chew, which interrupted their meal. The person was not supervised when taking this and began to cough. This had a detrimental effect on the person's mealtime and the amount of nutrition they consumed.

We saw one person tell staff they did not want any lunch. We did not see any staff try to encourage the person to have something to eat or ask them again later, and the person did not have anything to eat during lunchtime. We also saw one person had their meal removed by staff who did not ask if they had finished this.

Kitchen staff told us they were aware of people's dietary preferences and knew who required a specific type of diet. If anyone had any special diet they would provide this. A staff member told us they had altered one person meal to respond to a health issue.

A staff member was able to describe how to complete the food and fluid monitoring charts and understood how these helped ensure people had sufficient to eat and drink to meet their assessed nutrition intake each day. This was required to maintain the person's health and wellbeing. However we saw the chart for a person who needed their food and fluid intake to be monitored was incorrectly completed with both the amount of fluid and the type of drink consumed, so the record of what the person had during the day would be incorrect. We also saw more food and fluid charts in a people's files had not been correctly completed, so it was not known if their intake for those days had been the assessed amount for maintaining their wellbeing.

A relative told us they were happy with how a health condition their family member had was managed and that staff had called the emergency service when needed.

Requires improvement

Is the service caring?

Our findings

People felt valued by staff when they received care and support. A person who used the service told us, “The carers are good to me.” A relative told us they thought staff were, “Busy and attentive to residents’ needs.” We saw staff involved in conversations and light-hearted banter during the day, however we also saw that people went for periods of time where there was no interaction with staff. We saw one person spent a long period of time sat on their own, yet the information in their care plan suggested they enjoyed company and entertainment.

People who used the service and their relatives described staff as caring and compassionate, however some of them commented this did differ between staff, with some not being as caring as others. Staff were not seen as a united team and one relative commented there did appear to be cliques amongst the staff team, which meant there were some staff who did not work as closely, or effectively, with certain other staff members.

People were able to influence their care. One person had planned to go for a walk with a staff member but they had not been feeling well so they had decided to have a rest instead. Relatives told us that staff kept them informed about any incidents which involved their family member such as any falls or injuries. Relatives told us they did not have any particular involvement in planning people’s care.

We observed occasions where people’s privacy and dignity was promoted, for example we saw a housekeeper knock on a person’s door and ask before entering asked if they could come and clean their room. However we also saw occasions where people’s privacy and dignity was not promoted. We saw one person was administered eye drops at the meal table during a meal. On another occasion staff did not challenge a visiting healthcare professional when they did not provide someone with treatment in private.

Relatives told us there were no restrictions on visiting and some visitors brought pets which people enjoyed. We saw some pets were brought by visitors during the inspection. One relative told us they were able to make a hot drink for their family member and themselves in one of the kitchenettes which they thought was a good idea. Another relative told us that the coffee lounge was made available for family gatherings.

Requires improvement

Is the service responsive?

Our findings

There were two activity coordinators employed at the home. One of them told us about the activities programme which included a themed monthly dinner where relatives were invited to join in. A relative told us these were well attended, there was a good atmosphere and everyone seemed to have a good time. There were trips out of the home arranged to a local tea dance and day trips were organised such as to the seaside. A relative told us that their family member had been taken out for meal at a local pub.

On the day of the inspection there was a coffee morning organised in the café area. This was chaotic with too many people using the space available. We asked the operations manager to intervene as the situation was unsafe. An activity coordinator told us this activity had not gone as planned. There were televisions on in all the lounges and most people had their own televisions in their rooms. One person told us they enjoyed to read and had plenty of books available to do so. We saw me some of the craft activities that people had been involved in over the Easter period.

Relatives told us they felt that the care provided largely met the needs of their family members. One relative told us they felt staff knew how to provide the support their family member needed when they showed signs of behaviours that others may find challenging. However we found there had not been guidance provided for staff on how to support another person who displayed behaviour that posed a risk to other people.

People were not consistently offered the opportunity to make choices for themselves. We were told people were offered a choice of meal each day, however we did not see any evidence that this had taken place or how choices were provided to people who may need support to make this type of decision. Some people were asked at lunchtime if they want a "large, medium or small dinner" and others were not offered the opportunity to choose.

We saw occasions where people received care and support in an organised way in a relaxed atmosphere, such as at lunchtime in the café area. However we also saw times where things were disorganised and chaotic, for example a coffee morning activity, where we asked the operations manager to intervene as the situation was unsafe.

We observed lunch in one dining room and saw examples of people trying to manage their own meal and not being able to. Staff were rushed and did not give people the time they needed to eat their meal. We saw the meal time was poorly organised and people had to wait for their meal, were not offered a choice of drink and a relative had to request their family member was provided with their eating aid. We saw staff were supporting two people to eat their meal at the same time as there were not enough staff to help everyone individually. The mealtime did not provide people with a positive mealtime experience.

People's care plan did not provide staff with the information they needed to meet people' needs. Some visiting healthcare professionals had recently carried out a visit and had identified that people's care files were in need of review. The operations manager on duty acknowledged this and was in the process of auditing the files and we saw this was underway during our visit.

Staff did not routinely refer to people's care plans to know what their needs were and how these should be met. We saw a person was not given the assistance with their mobility as described in their care plan. A staff member told us they had not seen people's care plans.

Relatives told us that they knew who to speak to if they had a concern. One relative told us that they had raised a couple of issues with the manager. One was about uniforms and the other was to ask about the policy on ensuring agency staff were fully vetted. The relative told us that although they were not 100 per cent happy with the response they were happy that the issues had been fully discussed and considered. Another relative told us they liked to raise them with one of the nurses who they thought was very receptive and responsive. A relative told us there was a quarterly forum for relatives to attend.

There was a complaints procedure at the home where people could raise any issue they were not happy about. We saw there was a record kept of complaints made. There was one complaint which had been resolved.

Requires improvement

Is the service well-led?

Our findings

A staff member told us they did not feel situations were always managed as well as they could be, for example there had been some changes to the staff dress code which had not been received well by staff. Another relative also mentioned uniforms and said that it would be helpful to relatives to know who the staff were if they wanted to raise an issue. The operations manager told us that they had been having problems with staff following the provider's decision to change the uniform policy.

We found examples where staff were not properly managed. This included ensuring there were suitably skilled staff teams on duty and being supported when staff returned to work following injury. We saw a record of an injury to staff in the course of their duties that had not been properly recorded or reported. We saw staff did not always follow the policy of not having their mobile phones with them when working.

A staff member said there was a high level of absenteeism from work which caused problems. The finance director told us they had addressed some staffing issues to make improvements within the home. They said the new manager was going to be taking over preparing the rota as this had not been well managed.

Staff told us there was no provision made for them to pass on important information to the next shift of staff coming on duty about how people were and if there was anything they needed to know between shifts. However senior staff held a meeting after each shift in their own time to pass information on to the next shift.

There was not a system to use information gained through audits to identify improvements that could be made to the home. The accident and incident forms indicated there was a high number of falls occurring each month but this was not used to trigger finding ways to reduce these.

Records of accidents and incidents contained insufficient detail to enable subsequent investigation to take place. A staff member was unable to tell us what happened after an incident took place. There was no system to audit any complaints, concerns, compliments or suggestions made in relation to any aspect of the home by people using the service or their relatives. Audits of the medicines arrangements had not identified the issues we found requiring attention. Routine fire checks had highlighted issues with some of the fire doors and new ones had been ordered.

We had not been told about some incidents that had occurred at the home that the provider was required to tell us about.

All of the information above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a number of tensions and frictions within the staff team and staff identified a number of areas of concern. These included poor communication and a lack of support. One staff member told us morale amongst the staff team was low. Staff commented that they only tended to see senior staff when there was a problem.

Staff told us they did not feel supported in their role and some staff said they felt they were "put upon." Another staff member said there were strengths within the staff team, but less experienced staff were not being provided with the leadership they required to understand the full responsibilities of the work they were required to undertake. A staff member told us there had been very difficult times at the home and that staff gave as much as they could. One staff member did not want to talk to us out of loyalty to the home.

The new manager had commenced work at the home in February 2015 but had not yet applied to become the registered manager. The operations manager told us, "Parkside is a difficult home to manage". Staff told us the new manager was coming over as supportive and approachable. One staff member said the new manager was tackling issues and felt they were "Getting to grips with things."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person must assess the risks to the health and safety of service users and do all that is reasonable practical to mitigate such risks Regulation 12 (2)(a) and 12 (2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person must ensure the proper and safe management of medicines. Regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to assess, monitor and improve the quality of service. Regulation 17 (2)(a)