Indigo Care Services Limited

Green Park Care Home

Inspection report

Southwold Crescent
Great Sankey
Warrington
Cheshire
WA5 3JS

Tel: 01423859859
Website: www.orchardcarehomes.com

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 29 and 30 January 2019 and was unannounced.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve to at least good.

When we completed our previous inspection on 21, 22 and 30 November 2017 we found concerns relating to risk assessments not always in place resulting in a breach of Regulation 12 Safe Care and Treatment and also concerns regarding governance resulting in a breach of Regulation 17 Good Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We found on this inspection the provider was no longer in breach of Regulation 12 Safe Care and Treatment or Regulation 17 Good Governance. We did however, make recommendations within this report related to audits and oversight of all medicines management systems, staff deployment and also systems of confirming consent had been obtained from people.

Green Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is comprised of five units for people with dementia, nursing and residential care needs. They have a maximum of 105 beds and there were 93 people living at the home at the time of this inspection. A new unit had been opened since our last inspection for people with dementia care needs.

There was a registered manager present in post at the time of our inspection. 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.

A CCTV/Care Protect camera system had been installed since our last inspection. We found the provider had not recorded they had obtained consent or agreement from people prior to switching cameras on to film them in communal areas of the home.

The audits being undertaken which we viewed had not identified the issues highlighted on this inspection related to recording consent, issues were found regards high prescribed medicines stock and staff deployment.

We made a recommendation about systems of consent and audit processes not being robust enough.

Medicines had not always been managed effectively as we found high levels of stock which had not been

identified through the medicines audits we viewed.

We made a recommendation regarding medicine stock audits not being robust enough.

We received mixed feedback from people in relation to staffing levels to meet people's care needs.

We made a recommendation the provider reviews their systems of staff deployment within the home.

We found there were systems in place to assess and record risks for people. Electronic care plans we viewed included a range of risk assessments.

Some people 's fluctuation in their weight had been recorded and people were being referred to healthcare professionals.

The environment was appropriate for people living with dementia and there were activities within the home.

We found the home was clean and infection control standards were being met.

Most people were complimentary about the food and systems were in place to monitor people's food and fluid intake.
Safeguarding systems were in place and staff understood their responsibilities to report abuse.

Complaints had been dealt with appropriately and meetings with relatives/service users were taking place in the home.

Staff were receiving supervisions and appraisals. Staff were also receiving training with competency checks seen.

You can read about what actions we asked the provider to take at the back of this report.

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.

Risks were being identified, recorded with evidence of analysing them for trends/themes.

Safeguarding systems were being followed and staff understood their responsibilities to report abuse.

Infection control and cleanliness was up to a good standard.

Is the service effective?

Good

The service was effective.

Consent could not always be evidenced. We made a recommendation about this.

People we observed were being supported to eat and drink.

The environment was suitable for people living with dementia.

Is the service caring?

Good

The service was caring.

People's dignity was being respected and maintained.

Staff were inclusive, knew people well and were encouraging people to be independent.

Positive interactions were observed between staff and people living at the home.

Is the service responsive?

Good

The service was responsive.

People were receiving person centred care.

People's preferences, likes and dislikes were well documented and known by staff.

There was evidence of people's wishes and preferences being sought in preparation for their end of life pathway.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not always ensured people living in the home were being consulted with.

The provider's own audits had not identified all issues we found on this inspection.

There was effective leadership by the registered manager.

Green Park Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 29 and 30 January 2019 and was unannounced. We received an anonymous concern prior to this inspection related to people's care.

The inspection included a review of the new electronic care plan system, electronic medication administration system, we spoke with eight staff including the manager, reviewed care records, policies and procedures.

The inspection team consisted of two adult social care inspectors, a specialist nurse advisor 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 the inspection we reviewed all the information we held about the service including statutory notifications the provider sends to us of specific events or incidents and the most recent provider information return sent to us on 11 January 2019.

The methods we used included talking to people using the service, their relatives and friends or other visitors, interviewing staff, pathway tracking, observation and a review of other care records. 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 reviewed two staff recruitment files, four electronic care plans, one medicines round and associated electronic medication administration sheets (Emars).

We spoke with six people who lived at the home and five visitors/relatives. We had the opportunity of speaking with one visiting healthcare professional and gathered information from the local authority and

commissioners.

Good

Is the service safe?

Our findings

We asked people who lives at the home if they felt safe. Everyone we spoke with told us they felt safe with the staff at the home.

We viewed two staff files and found recruitment practices were robust in the home. There were application forms, interviews completed, reference checks and a Disclosure Barring Service (DBS) check undertaken which means the provider was checking if anyone had any previous convictions. We viewed DBS certificates with previous convictions which the provider had risk assessed as part of the recruitment process.

There was a safeguarding system in place and a tracker for each of the five units at the home. Staff understood their responsibilities to report different types of abuse to keep people safe. There was a whistleblowing policy in the home.

There were safe systems in place within the home. Personal emergency evacuation plans (PEEPS) within the home were reviewed and we found they were being checked on the first day of each month. They detailed if the person had a sensory impairment and what level of assistance thy would need in the event of a fire. Fire drills had taken place in the home and staff were receiving fire training.
There was plenty of personal protective equipment seen during this inspection. Staff were observed replacing their aprons/gloves in between care tasks which meant they were following infection control guidance to reduce the risks of infections across the home. There had been an infection control external audit completed on 24 January 2019 by the Local Authority. We viewed the report and found they had been awarded 95 percent which means they were compliant.

We checked whether risks were being identified and reviewed. The care plans we viewed had been uploaded on an electronic system which meant staff were uploading information as and when they were delivering care on a phone. There were risks detailed within care plans we viewed including people's risk of malnutrition, falls and moving and handling. Staff confirmed anything which was a risk was "flagged" to them on their phone for them to be aware.

We checked the management of medicines within the home by checking the electronic system in place, observing practices within the home, checking stock levels and how covert administration practices were being managed.

We found Pro ra Nata (PRN) which means as and when needed medication comprehensive protocols were in place within hard copy Medication Administration Sheets (MARS). The qualified staff were unable to locate an electronic protocol version however, the registered manager confirmed they intended to have both hard copies and electronic copies in the future. An electronic facility was available to record rationale for PRN administration and record when administered.

The medicine trolley was uncluttered and clean. We observed the medicines trolley was locked when unattended and chained to the wall in clinic rooms we viewed. A selection of drinks to assist patient to take

medicines were made available and single use presentation medicine pots were in plentiful supply. The staff who were administering prescribed medicines wore a red 'Do Not Disturb' tabard throughout the medicines round. The electronic system held patient photographs and 'demanded' administration entries to be made before each patient medicines intervention was completed.

We also checked the system of storing and recording administration of controlled drugs which are prescribed medicines controlled under the Misuse of Drugs legislation. We undertook a spot check on one unit found the stock corresponded with the records within the controlled drugs register. The clinic fridges checked were in good order with evidence seen of daily temperature checks that were within safe limits.

We checked the ordering and stock control of prescribed supplements and found there were 32 servings of one person's prescribed supplement and 40 of another prescribed supplement within their use by date. We also viewed a high number of another prescribed supplement for the same person. The qualified staff we spoke with could not explain the high stock amounts as they told us they had administered the supplements and there were records to confirm all but one supplement was administered according to the MARS. The registered manager was investigating this at the time of this inspection.

We recommend a review of all systems of auditing stock amounts of stored prescribed medicines to include prescribed supplements within the home.

The qualified staff we spoke with told us they ensured they administered supplements before electronically signing off but could not provide an explanation for high stock levels suggestive of their not being administered. Recent weight loss issues were being recorded and attributed to periods of a decline in physical health. We could see in the records people's weights were improving when they had recovered from a period of ill-health.

We viewed the rotas and spoke with people about staffing levels. There was no system in place for the provider to monitor call bell response times. The registered manager confirmed if they were aware people who needed additional assistance and were waiting for a response to their call bell they would increase the checks undertaken for the person. One person told us they found they had to wait a long time for a response to them pressing the call bell. The provider showed us they had increased their checks on the electronic care system for the person to ensure they were not waiting for a response to their call bell. Other people told us staffing was not an issue and there were enough staff. People said they considered staffing at night time and weekends was an issue. Our own observations were that staff were observed delivering task focused care at certain times of the day on different units. Therefore, we found staff deployment an issue at these times of the day as opposed to staffing numbers.

We recommend the provider reviews their systems of staff deployment to ensure people's care needs are met at all times.

Incidents and accidents were being recorded and logged. We viewed one person's incident forms and saw that they had been analysed for trends or themes. Staff knew what to do if they witnessed an incident or if they needed additional assistance.

Good

Is the service effective?

Our findings

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 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 checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

The registered manager had implemented a DOLS tracker with people's authorisation application dates, date when the authorisation was granted and whether there were any conditions which needed to be implemented. We undertook a random check of the DOLS and found those with conditions were being implemented. There was a Mental Capacity Act 2005 framework seen in the records.

We looked into whether consent was being sought from people. The provider had implemented a CCTV/Care Protect camera system in the home. Cameras were activated within communal areas however, the provider could not provide confirmation they had sought consent from people prior to them switching cameras on within communal areas. Following the inspection, the provider sent us a copy of a consent form template which included a section on consent to cameras in communal areas. We were also provided with a generic best interests form signed by a qualified staff member which did not meet the requirements of the Mental Capacity Act 2005. The Mental Capacity Act 2005 requires individual decision specific assessments to be completed for each person and not generic best interests for a group of people who lack capacity. The provider had considered the requirements under the General Data Protection Regulation (GDPR) but the provider had not documented consent had been sought from people living at the home. We received evidence of this following our inspection.

We recommend the provider reviews their processes and systems of seeking and recording consent.

We looked into staff training and asked individual staff members about their understanding of consent and the Mental Capacity Act 2005 (MCA). The qualified staff we spoke with had a limited understanding of their responsibilities in relation to following the Mental Capacity Act 2005. The record of staff training was in the process of being transferred onto an electronic system. However, we were able to view the training matrix which highlighted one staff member's safeguarding training had expired and three staff members MCA 2005 training had also expired. The registered manager assured us the staff who's training had expired would be completed as a matter of high priority. Staff we spoke with told us they were receiving training both on-line and face to face. Staff also confirmed they were receiving regular supervision and appraisals, evidence of

which was found in staff files we checked.

We looked into how best practice guidance was being implemented within the home. We found some best practice in relation to dementia care which was being implemented by the provider's head of dementia services across all their homes. For example, all the staff working on the Kensington Unit which was the new dementia plus unit had received training in how to communicate with people living with dementia. This was evident during our observations of how staff interacted with people. We spoke with the head of Dementia services and they showed us their research into a new model of care being developed. This guidance incorporated best practice guidance including from the National Institute for Care Excellence (NICE).

We observed the dining experience for people on four of the units and we found the atmosphere in all dining areas was calm and a pleasant environment for people. Tables were covered in a table cloth, serviettes and appropriate glasses and cutlery were seen being used. People were entering the dining rooms when they wished and were supported to eat and drink a choice of foods and drinks. We over heard people being provided a choice of three different lunches but only one choice of desert which was rice pudding. We were informed by staff that everyone could have an alternative to rice pudding if they asked for an alternative. We considered that for some people living with dementia they would have difficulty thinking of an alternative and providing a choice would assist them.

People we spoke with were complimentary about the food and people told us they were eating enough. For example, one person said, "The food is too much here, they never seem to stop feeding me." Another person we spoke to said "the food is very good, a third person told us they had previously complained about the portion sizes. We observed staff were offering people more when they had finished and encouraged people to eat what they wished.

People's weight was being recorded and monitored using Malnutrition Universal Screening Tool (MUST) scoring system. Referrals had been made to Speech and Language Therapy and Dietician's for their professional input. Food and fluid charts had been replaced with the electronic system of staff entering into the system when people had eaten or had a drink using their mobile phone. We viewed the system and found it confirmed when people had last had a drink or food so people's nutritional intake and fluid intake was being monitored.

We spoke with the chef and viewed the kitchen area. We found there was a temperature probe to ensure the food was cooked and warm prior to being transported on a heated food trolley to each of the five units. The kitchens were being cleaned regularly as seen on the rotas and they had recently been provided with a new dish washer and steamer. The chef also confirmed they had requested a new cooker and this was approved by management. There were two choices of each meal seen on the menus and a white board with any allergies recorded. There were deliveries of fresh food weekly and a diabetic range of foods.

The environment had improved and had appropriate signage for people living with dementia. There were numerous interesting items for people to see and touch including memory boxes with photographs of the person when they were younger. There was a newly installed nail bar room for people to have quiet time to have their nails painted and the hairdressers we viewed had recently been painted. The registered manager told us they wished to further improve the environment design by creating a sensory garden outside for people living with dementia.

Good

Is the service caring?

Our findings

We asked people and their relatives/visitors how they were treated by staff at the home and we received mixed responses.

One person told us "Oh yes, they (staff) are very friendly", another person said, "very friendly", a third person we spoke with told us staff treated people differently from each other and they had their favourites. Another person said "Ninety% are polite but you just get the odd one or two that aren't". A fifth person said, "they (staff) are very good, look after you". Another person said, "staff all have a good approach, nothing bad to say about the staff". One relative we spoke with said "only a couple of them had any kindness and compassion."

We made observations regards people's dignity and found people's appearance was well kept, indicating people were receiving personal care which respected their dignity. People we spoke with told us staff would knock before entering their room and respected their privacy. Relatives we spoke with told us they were able to visit anytime and were provided with privacy by staff. Staff supported people to maintain their relationships with others and were observed responding positively when relatives wished to speak with them.

We observed people walking around freely and staff were observed maintaining a calm, respectful, dignified approach to care delivery. The care delivery approach was to be inclusive of people and respect them as individuals. Staff knew how to communicate with different people and tailored their approach according to the person's level of communication. For example, we observed one person living with dementia having difficulty with the task of holding a plate and eating from it. The staff member observed they were having difficulty and supported them by placing the sandwich in the person's hand. The person was then able to eat the sandwich independently. This maintained the person's independence and dignity by discreetly supporting them. Another person was observed standing or walking around the dining room. A staff member recognised they did not wish to sit down and therefore, encouraged the person to join them in setting bowls out in preparation for dessert.

We heard the staff offering people choices including a choice of where to sit, a choice of drinks, whether they wished to be in their room or lounge. One person we spoke with said, "always have a choice". Staff including the registered manager knew people well, including some people's life stories who lived there. Staff were seen delivering task based care at times and had minimal opportunity to sit and spend time conversing with people.

Residents/relatives meetings were being held within the home with actions of how to make changes for improvements. This meant people were being listened to as actions were being put into place.

The registered manager could confirm who within the home had a power of attorney or lasting power of attorney and how to access advocacy if needed. We viewed the home had an equality, diversity and human rights policy for the home.

Good

Is the service responsive?

Our findings

People were receiving person centred care. For example, we observed one person who was living with dementia who repeatedly placed themselves down onto their knees onto the floor and back up again. We observed they had been provided with knee pads to protect their knees from injuries and to provide cushioning when they placed themselves onto the floor. Other people living with dementia were observed walking around the unit corridors as they preferred to walk as opposed to sitting down. Staff were aware of people's preferences and knew when to intervene and when not to intervene maintaining a calm atmosphere.

People we spoke with confirmed people were receiving person centred care, for example, one relative told us, "it's so good here, my grandfather receives really good care, the staff know everything about him". For people who lacked capacity, relatives were being included within care planning and were being asked about people's likes and dislikes.

People's care needs were being assessed prior to them living at the home and assessments were regularly reviewed including when there was a change in a person's health or functional ability.

Activities were being provided within the home. We reviewed research undertaken by the activities coordinator into how to best tailor activities for different people who were living with dementia. We saw numerous pictures which were recent since the last inspection of people enjoying various activities. The activities coordinators had implemented a painting session for people where people were encouraged to paint using water colour paints. The paintings were on display in the home.

The activities coordinators had met with people and relatives to ascertain their wishes and preferences for activities in the home. There was a social media account for the home which we viewed during this inspection and found communications and pictures being shared to enable people to keep in contact with people and events in the home. Music pertinent to the preference of a person living with dementia had been downloaded onto their own MP3 music player. This provided each individual person with the music of their choosing to provide them with comfort and stimulation.

There was a system of handling complaints in the home and we found investigations and responses to people's complaints by way of a written letter to the complainant. Some people we spoke with told us they had previously made complaints and they had been dealt with and resolved. There was also evidence of an analysis of complaints.

There was no one receiving end of life care at the time of this inspection. We found people's wishes and preferences were being recorded in relation to what they wished to happen in the event of their deterioration towards the end of their life. There was provision for "just in case" end of life prescribed medication available for one person who had deteriorated but then had subsequently improved.

Requires Improvement

Is the service well-led?

Our findings

The rating was displayed in reception so visitors could easily view it. The website also included the most recent rating with the report for people to easily access it.

There was a new registered manager in the home who had taken up post as manager since the last inspection. They confirmed they had primarily focused on ensuring all care plans were transferred across to the new electronic system and had achieved this. The provider and registered manager had also implemented a new electronic medication administration system and installed a Care Protect camera system since the last inspection.

The registered manager was present for the duration of the inspection as was a quality manager who was in the home completing a quality audit. The head of dementia services for the provider was also present for the second day of this inspection. There was effective leadership by the registered manager.

People we spoke with were complimentary about the management of the home. Not everyone we spoke with said they had met the manager and were unsure who the manager was. We made observations and found the manager knew people living at the home well, they were warm and empathetic towards people. Most staff we spoke with told us they found the manager approachable.

We viewed the quality assurance files and found the registered manager had undertaken daily walk around spot checks, night time spot checks, daily flash meetings with clinical leads and qualified staff. There were falls management meetings with actions seen to reduce falls and to identify trends/themes.

Each unit had its own quality assurance file containing an index of a variety of completed audits.. These included audits in care planning, medication, pillows, skin tears, monthly accidents, falls, infection control, catheters, mattresses, pressure cushions, complaints, bed rails, bed grab rail, weight loss, weights audit, pressure sores, survey action plan, clinical governance and dependency tool. There was a percentage of compliance being awarded for each care plan audited to continually improve the care plans. Medication audits seen had actions for improvements such as to ensure reasons for none administration were being recorded, ensure any medications regularly refused were referred back to General Practitioner. People's weights recorded for December 2018 were seen recorded and flagged up where weight issues needed to be discussed at weight loss meetings. This meant we could see the service was auditing and looking for how they could improve their practices following each audit.

Some people we spoke with had concerns about staffing meeting people's needs on this inspection. Staffing was being addressed within the home with on-going recruitment. Although people's dependency levels were being regularly reviewed and regular spot checks were seen in the quality assurance file we viewed, we found staffing had not been identified as an issue. People had concerns about staffing at key times of the day/night and weekends. We asked to view call bell response times to check how long people were waiting from the time they pressed the call bell. We were informed by the registered manager the system did not allow for print outs. This meant the provider and registered manager had no means of checking call bell

response times for people and relied upon their own observations. We discussed this with the registered manager who told us they would review staff deployment to ensure people were receiving their care when they needed it and made a recommendation about this.

We found the governance and quality checks including medication audits had not dealt with the issue of the excess stock of prescribed supplements. They had built up in the home on one unit since October 2018. We observed there was an excessive amount of prescribed supplements seen stored in the cupboards on one unit. The registered manager told us they considered the reason for the excess stock to be due to an excess ordering issue as opposed to an administration issue. Never the less this had not been addressed in the home.

The provider had installed Care Protect cameras within the home and had informed CQC about this prior to this inspection. As part of this inspection we asked to view the provider's system of explaining this to people and how they had sought consent. The provider had met with staff and relatives to explain the camera system but there was no evidence they had met with individual people living in the home to explain the system and to seek their agreement for them to be filmed on camera in communal areas. The General Data Protection Regulation (European Union) 2016/679 ("GDPR") is a regulation in EU law on data protection and privacy for all individuals within the European Union. There is a right to privacy and a right to object to an infringement of someone's privacy under this legislation. Following the inspection the registered manager provided us with confirmation they had sought consent from people retrospectively.

We recommend the governance systems and oversight of audits and quality checks being undertaken are reviewed to always ensure audits are robust.