Parkside (St.Helens) Limited

Parkside Care Home

Inspection report

280 Prescot Road
St Helens
WA10 3AB
Tel: 01744 452160

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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?	Inadequate

Overall summary

This was an unannounced inspection, carried out on 5 November 2015.

Parkside Care Home is a residential care home in St Helens. The service offers accommodation and support for up to 30 people. The building is arranged across two floors with lift, staircase and stair lift access to the upper floor. There are 24 single rooms and three shared rooms. Twenty one rooms have ensuite facilities. Car parking is available at the front of the building.

The service has 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.

The last inspection of Parkside Care Home was carried out in December 2013 and we found that the service was meeting the regulations we reviewed.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager confirmed they did not have a policy or procedure in place to ensure that the Mental Capacity Act was implemented.

The home was in the process of having building works undertaken. There were no risk assessments in place outlining risks to individuals. The Registered Manager had put no entry signs on the doors where building works were taking place however; doors were not locked to ensure people's safety. Work areas were left open during the time of the inspection and this meant people were not safe from potential harm.

Accidents and incidents were recorded however there was no evidence to show that people's care plans had been reviewed or updated following these incidents. This meant that risks to people had not been considered and when appropriate, minimised. Records showed that some people had experienced falls however risk assessments had not been reviewed to consider minimising future risks from falls. Care plans still stated that people were independently mobile although there mobility had deteriorated either prior too or following a fall.

People's nutritional needs were met and choices were offered at each mealtime. Individual dietary requirements were supported to meet the needs of people living at the home.

People received their care from people who were of suitable character and the registered provider has safe systems in place for the recruitment of staff. Staff attend regular training sessions in areas including moving and handling, first aid and safeguarding adults to update their knowledge and skills.

Systems in place were not robust and therefore we could not be sure the service was managed effectively and in people's best interest.The Registered Manager had not ensured falls risk assessments had been updated following people experiencing falls and therefore any additional risks to the individual had not been considered. Accidents and incidents were recorded, however there was no evidence of analysis to determine any actions to be taken to minimise future risk.

Policies and procedures available all required reviewing and updating.

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?

Requires improvement

The service was not always safe.

Accidents and incidents were recorded although analysis of these was not in place. Reviews of care plans and risk assessments following events were not evidenced.

The building was not secure at all times with doors including fire doors being left open and unsupervised.

People told us they felt safe. Staff had attended safeguarding training and had an understanding of abuse and how to protect people.

Recruitment procedures were in place to ensure only people of suitable skills and character worked at the service.

Is the service effective?

Requires improvement

The service was not always effective.

Information within the care plans did not always reflect changes that had occurred to people's needs and contained inaccurate information.

Staff did not have access to regular supervision and meetings with the registered manager.

Each person had a file in place detailing their needs and preferences. People had been asked about their likes, dislikes and choices. This demonstrated a person centred approach.

Is the service caring?

Requires improvement

The service was not always caring.

The service did not always respond to people's health needs in a timely way.

Daily records demonstrated an uncaring approach within the writing of documents.

People and their family members told us that the staff were kind and caring.

We saw that people were treated with dignity and respect and had good relationships with staff.

Is the service responsive?

Requires improvement

The service was not always responsive.

Information within the care plan files was not up to date and did not accurately reflect the care being given.

People's care needs were appropriately assessed and planned for.

Summary of findings

People and their relatives knew how to make a complaint and were confident that they would be resolved.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of effective quality assurance systems to ensure that improvements were made to the service people received.

The homes policies and procedures were all out of date and required review.

A registered manager was in place, who had a good understanding of the improvements that were needed to improve the service that people received.

Parkside 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.'

This inspection took place on 5 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors.

During our visit we spoke with six people who used the service, three family members and five staff. We also spoke with the Registered Manager. We looked at three people's care records and observed how people were cared for. We toured the inside and outside of the premises including people's bedrooms. We looked at four staff files and records relating to the management of the service.

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.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since the last inspection and information we received from members of the public. We contacted the local authority, healthwatch and the infection control team to gain their views of the service

Requires improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. Their comments included "I feel very safe here and I chose to live here after I had visited for respite". Relatives commented "I feel that my Mum is very safe here".

On arrival at the service we were advised that building works were underway. There were no entry signs in particular areas and the Registered Manager confirmed she had ensured barriers were erected whilst the work was in progress to prevent accidents. However they also confirmed that risk assessments had not been completed outlining risks to individuals.

On the morning of the inspection the dining room had been mopped and the floor was slippery. One person was still eating their breakfast. A member of the domestic staff said she had left a safe walkway although no hazard signs were in clear view.

Throughout the day several fire exits were left open and unsupervised. This happened on three occasions. The home was not secure at all times due to the front and back doors being unlocked and at times were open without staff present. One member of staff said "It is very rare for us to lock the front door". People at the service were vulnerable to others entering the building uninvited.

Before the inspection we were informed of concerns relating to the care of a person who used the service. This is currently being investigated.

We found that people were not always protected from risks to their health and well being. We saw risk assessments relating to people's needs were available in relation to moving and handling as well as falls. However, the quality of the care records was inconsistent and did not always provide sufficient detail for staff about how to manage specific risks. For example, one person's support requirements regarding mobility had changed from 2:1 staff required for moving and handling to becoming independent. The moving and handling risk assessment did not reflect this change and therefore put the person at risk from not receiving the care and support they required.

Accidents and incidents were recorded by the Registered Manager however, they had not demonstrated that they had considered future risks to individuals or amended the care plan files. An example of this was that one person had experienced three falls within one month, the risk assessment had not been reviewed and the care plan had not been updated following these falls. Another person had experienced eight falls since their admission to the home. The falls risk assessment had not been updated to demonstrate this. Failure to consider all known risks to people may result in them being put at risk from unnecessary harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the registered provider must ensure that they are doing all that is practicable to mitigate risks.

The environment was clean and hygienic. Staff had completed infection control training and they had access to information and guidance in relation to the prevention and control of the spread of infection. Personal protective equipment (PPE) including disposable gloves and aprons were located around the service and readily available to staff. Staff used PPE as required, for example when they assisted people with personal care.

Staff recruitment was managed safely. We reviewed four staff record files and found they included completion of an application form, interview records, staff recruitment checks, such as obtaining two valid references from previous employers and verifying people's identity and right to work. Necessary vetting checks had been carried out through the Disclosure and Barring Service (DBS). These checks identified if prospective staff had a criminal record or were barred from working with children or people at risk.

Staff had received training on safeguarding adults. Staff spoken with demonstrated a good understanding of abuse. They described the different types of abuse and signs which indicate abuse may have taken place. They talked about the steps they would take to respond to allegations or suspicions of abuse. One member of staff told us "People have the right to feel safe and be protected from abuse". Staff were aware of their own responsibilities under the Care Act 2014 to raise a safeguarding concern with the local safeguarding team. A copy of the local authority safeguarding policy and procedure was available although the registered provider did not have an up to date safeguarding policy and procedure to reflect their practices.

Requires improvement

Is the service safe?

There were enough staff working on the day of the visit to keep people safe and meet their individual needs. Staff told us they felt the staffing levels were safe and they had time to provide people with the care and support they needed. Staff rosters for the previous month showed that there had been a consistent number of staff on duty over this period. Staff responded to call bells in a timely manner throughout the day. People told us "staff answer my call buzzer promptly" and "staff respond very quickly to my call button".

The service had an appropriate system in place for the management and administration of people's medicines. Staff followed current regulation and good practice guidance. Staff administering medicines had undertaken appropriate training for this role. Medicines were stored in locked cupboards and the medicine room was kept locked at all times. The medicines fridge was kept locked and the temperature of this checked and recorded regularly. People received their medication on time and in a safe manner.

Requires improvement

Is the service effective?

Our findings

People's needs were assessed prior to them moving into the service. One person told us they had visited the service ahead of moving in and had chosen their own room. Each person using the service had a care plan file in place which detailed their needs and preferences. There was evidence that people using the service were asked about their health, likes, dislikes and general routines at the time of moving into the service which were included in the initial care plans. We looked at three people's care plans during this inspection and these were all dated July 2015. The care plans dated July 2015 were person centred and clearly detailed actions to be taken. Reviews of people using the service were not clearly documented. One person's care plan stated that they had bi monthly reviews but the last one documented was June 2014. Another person's bi monthly review was last documented in December 2014.

One person's records clearly demonstrated a deterioration of health and well being although staff had not responded promptly to this information. The records showed a deterioration in the physical health of the person but this had not been responded to in a timely manner. Medical advice was sought by the visiting district nurse. Care plans did not reflect the actions being undertaken within the daily notes. This meant information was not up to date and accurate which could be misleading for staff.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider must ensure they are doing all that is reasonably practicable to mitigate risks.

The Care Quality Commission (CQC) is required by law to monitor the operations of Deprivation of Liberty Safeguards. We discussed the requirements of The Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the Registered Manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

The Registered Manager had attended training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed that some staff had attended MCA and DoLS training. Through our observations staff demonstrated a basic understanding and awareness of the Act. During our inspection we heard staff ask for consent before carrying out activities. For example, staff asked people before they assisted them out of chairs within the lounge area or with sitting down in the dining room. They also asked people if they required assistance with personal care activities throughout the day.

The Registered Provider did not have their own policy or procedure relating to the MCA requirements. There was a local authority flowchart on the office wall for the DoLS process, however this needed to be incorporated into the organisational policy and procedure.

Care planning records demonstrated evidence of capacity assessments although best interests decisions were not recorded. This meant that the principles of the law were not followed when making decisions for people who lacked capacity and needed their liberty restricting for their safety.

The Registered Manager had applications prepared for the local authority on behalf of people in relation to Deprivation of Liberty Safeguards (DoLS) authorisations. The applications were unclear and did not clearly demonstrate the reason for application. The Registered Manager stated she would be applying for (DoLS) authorisations for all service users who did not independently leave and return to the service. Providers must always consider each person separately to decide both if they are likely to be deprived of their liberty, and also whether, and how, restrictions on their freedom can be reduced or removed. Only if they are sure that deprivation of liberty is necessary and proportionate for that individual, must they request authorisation.

Of the five staff records reviewed only one file had any evidence of supervision documentation. Supervision can support staff to develop their understanding of their role and the people they support as well as develop their working practices. Only one member of staff spoken to confirmed they had received a supervision with the registered manager.

Staff were knowledgeable about the care and support people needed. Staff explained their role and responsibilities and how they would report any concerns

Requires improvement

Is the service effective?

they had about a person's health or wellbeing. However appropriate referrals have not always been made to other health and social care services. For example: Records showed that medical intervention had not been sought in a timely manner following a person having a fall and suffering an injury. Medical advice had not been sought immediately and when the service did receive guidance it was not followed. This meant people did not always receive prompt intervention when required. Care plans did not always reflect the care being given. This meant that if a member of staff needed to support a person unknown to them the up to date information was inaccurate. Someone may receive incorrect care and support. An example was a person having wound care and dressings by the district nurse team. The care plans did not reflect this or evidence care required in between district nurse visits. There was no record of district nurse visits or frequency.

People were complimentary about the food. Comments included "The food is good and I always get offered a choice", "I like the choice of meat or fish every day" and "I know I can ask for something else if I do not fancy what is on offer".

The mealtime experience for people offered choices of food and drink as well as alternatives when people did not want what was on the menu.There was a relaxed atmosphere within the dining room and people chose or were asked where they would like to sit to eat their meal. People's care plans contained information about individual dietary requirements and these were provided. For example, one person required a gluten free diet and the menu had been adapted to meet their needs. This person was still offered a choice and this had been observed earlier in the day.

People did sit for a short time ahead of the meal being served but they appeared relaxed and comfortable and were having conversations with each other. The meal was served from serving dishes and choice was offered throughout this. People were offered assistance and support when required. Food presented looked appetising and appeared hot. People appeared to enjoy their meal and were seen to be engaging in conversation throughout the mealtime.

We recommend that the provider improves the procedures, documentation and recording systems in place to ensure that the Mental Capacity Act 2005 is fully implemented.

Requires improvement

Is the service caring?

Our findings

People told us positive things about the staff team. Their comments included “Staff are smashing”, “All staff are lovely and caring” and “All staff are nice and I can talk through any problems I have with them”. A visiting relative told us “The staff are marvellous” and “I am always kept informed of any concerns regarding my relative’s health”. Another relative told us “The staff are very friendly and always offer me refreshments”.

Staff were observed being respectful of people’s privacy and knocked on bedroom doors before entering. We observed staff calling people by their preferred name and listening to what people wanted.

Staff responded to people’s needs promptly during the day. Staff appeared to have a good understanding of people’s needs and preferences when attending to their needs. However, staff undertook cleaning and the mopping of a floor while someone was still eating their breakfast which demonstrated that staff had not considered that this was disrespectful of the person still eating.

Daily records were maintained of what care and support people had received or had been offered throughout the day. We saw that one individual’s daily records were not always written in an appropriate manner as several inappropriate comments were found. This demonstrated that some staff were not always caring towards people who used the service. This was discussed in detail with the Registered Manager who confirmed they would take action to address this.

People were encouraged to make choices and their independence was promoted. People were given choices about what they wanted to eat and drink and where they preferred to spend their time. Two people told us they liked to carry out small tasks such as setting the tables at meal times, folding linen napkins and tea towels as well as tidying their bedrooms to maintain their independence. They stated that they were purposeful activities that make them feel useful as well as passing the time.

Staff were observed supporting people in a caring manner and were offering choices throughout the day. Examples were when offering refreshments including hot and cold drinks choices. Staff responded promptly when a person requested support and offered this sensitively.

Requires improvement

Is the service responsive?

Our findings

People told us they received the care and support they needed and were also encouraged to be independent where possible. One person said "I chose to come and live here and chose my bedroom too", another said "If I've got a problem I can talk it through with staff", and "Staff answer the call buzzer very promptly when I need help".

Information recorded in some people's care plans did not reflect the care the person required. Diet and weight charts were not fully completed and up to date, wound care plans were not always in place for people although wound care was noted within daily records. Staff spoken with had an understanding of the support needs for people. Written records viewed were not accurate or fully completed.

The care files included a pen picture which appeared to demonstrate changes, new instructions and evaluations. The care plan file documents had not been updated in line with the pen picture causing the system to be confusing and unclear. This meant people may not have been receiving the most up to date care and support to meet their needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had differing views regarding available activities within the service. One person said "I enjoy joining in the singing", another person said "There are activities in one of the lounges including hoopla, play your cards right, as well as visiting entertainers including banjo players and singers". Two people stated they were not aware of any activities and had not joined in any. However on the day of the inspection there was a visiting singer who sang songs from the 40's, 50's and 60's. Twelve people were in the lounge with the entertainer and appeared to be joining in and singing along.

Relatives told us they would talk to the staff or registered manager if they had any concerns. One person said "I haven't had cause to raise a concern but wouldn't hesitate if I needed too. I think I would be listened too". Relatives knew how to raise concerns and were aware of the registered provider's complaints procedure. The registered provider had a system in place to record complaints. Records showed that the service had received a small number of complaints since the last inspection and that they were dealt with appropriately. However the complaints policy had inaccurate information within it. It referred to a previous regulator and not the Care Quality Commission (CQC).

Inadequate

Is the service well-led?

Our findings

The registered manager had been registered with CQC since 2011.

An agenda and notes were shown from a recent staff meeting although previous minutes from staff meetings were unavailable on the day of inspection. Staff told us that "Staff meetings were generally informative and fun". It was unclear how all staff were to receive the information from the staff meeting should they have not been in attendance.

The registered provider had a system in place to assess and monitor the quality of the service that people received. However, we saw that these systems were not always effective. For example, the auditing systems in place had failed to identify a need for risk assessments and care plans to be updated following the completion of incident and accident forms.

The food hygiene audit was not dated and did not clearly identify actions to be taken and by whom when areas of improvement had been identified. No timescales for completion of actions were shown.

Before the inspection we were informed of concerns relating to the care of a person who used the service. This is currently being investigated.

Weight charts were used to monitor people's weight. Some charts did not have dates so it was unclear when the information had been recorded. This meant information was not up to date and could mean important weight loss or gain for people may not be acted upon and therefore place individuals at risk from unnecessary harm.

One person had experienced eight accidents resulting in falls since their admission however, their falls risk assessment had not been updated and therefore any additional risks to the individual had not been considered. This meant future risks were not being considered to reduce the risk of falls.

On the wheelchair risk assessments where risks had been identified, actions or interventions were not demonstrated on any of the documents. One document stated there was a risk due to the wheelchair or occupant being heavy or difficult to push. The staff were potentially being placed at risk without an action plan in place.

Accidents and incidents were recorded, however there was no evidence of analysis to determine any actions to be taken to minimise reoccurence. Falls risk assessments were not reviewed following people's accidents, this meant action may not be taken to prevent a reoccurence.

The registered manager had produced a risk assessment for people using the service to access the stairs. This information did not extend in to people's individual care plans. Information was unclear within the care plans viewed regarding people accessing the stairs or lift and the amount of support required for this.

The policies and procedures were out of date and two members of staff confirmed the policies and procedures we looked at were the ones they used for reference. The complaints policy had incorrect information in it. This meant people may not contact the correct person or authority to support them with their concern or complaint. The home did not have a policy in place for the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS). A local authority flow chart was on the office wall for the DoLS process but this was not incorporated into an organisational policy specific to the home. The policy for Safeguarding was out of date and referred to the National Care Standards Commission (NCSC), however the Registered Manager stated they followed the local authority Safeguarding procedure and flowchart. The flowchart referred staff to the St Helens Council but did not outline the home's responsibilities.

The provider did not have a Whistleblowing policy and procedure in place. Through discussions with staff they were aware of how to report any concerns they might have regarding the conduct of colleagues and were confident their concerns would be addressed.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.

The registered manager had informed the CQC of specific events that they are required, by law to notify us about. They had reported some incidents to other agencies when necessary in order to keep people safe and well. However a recent significant event had not been reported

Inadequate

Is the service well-led?

appropriately resulting in a delay of investigation and treatment. This meant people were not always being responded too promptly and did not receive treatment and support tailored to meet their individual needs.

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 provider failed to take all reasonably practicable actions to mitigate risks. 12(2)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider failed to provide care and treatment that was appropriate to meet the needs of the people using the service and reflecting their preferences. 9(1)(a)(b)(c)**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not meeting this regulation because: The registered provider did not have systems and processes in place to assess, monitor and improve the quality, health and safety of those using the service. they also failed to keep accurate and complete records. Regulation 17 (1) Regulation 17 (2) (a) (b) (c) (d) (e) (f)

The enforcement action we took:
We issued a warning notice and told the registered provider to be compliant by 12 March 2016.