Western Park (Leicester) Limited

Western Park View 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 13 and 14 October 2014 and was unannounced.

Western Park View Nursing Home provides accommodation and nursing care for up to 60 people accommodated over three floors. This includes care of people with learning disabilities or physical health needs. On the day of the inspection 46 people were living at the home. 16 people were living with dementia.

At the last inspection on 2 April 2014, we asked the provider to take action to make improvements. We issued compliance actions to improve the care and welfare of people living at the home, the premises, supporting staff with adequate training and supervision and ensuring the provider had systems to check their services met the needs of the people living in the home. At this inspection we found the provider had made improvements in relation to the premises.

Summary of findings

There was a registered manager in post when we visited. 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 and associated Regulations about how the home is run.

People who lived at the home and their relatives told us and our observations showed that staff were not always available at the times people needed them. This was despite staffing levels during the morning period having been increased since our last inspection. This meant that people did not always receive care and support that met their individual needs and preferences and their safety was, on occasions, compromised.

People were not always supported by staff who had the knowledge and skills to provide safe and appropriate care and support. This was because not all training had been provided relevant to their job roles and opportunities for staff supervision were limited.

People told us that any complaints, concerns or issues they raised were not always dealt with, in order to improve the service they received.

The views of people who lived at the home and the staff team about the quality of service provided were sought. However they told us that suggestions put forward and issues they raised with the management team were not always acted upon.

Systems in place for checking the quality and safety of the service and the care people received had not identified a number of shortfalls in the care and service provided. This meant that a number of issues had not been addressed for the benefit of people who lived at the home.

Risks to people's health had been identified and measures put in place to reduce these risks. Most people received their medicines at the right time and in a safe way.

People felt safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents. However one incident had not been reported to the appropriate agency to ensure this person's safety had been protected.

Satisfactory pre-employment checks had been carried out for all staff. This meant people were protected from the risk of unsuitable staff.

People were given sufficient food and drink to meet their dietary needs and had a choice of what food they were given.

People were supported to maintain their health needs. Referrals were made to health care professionals for additional support or guidance if people's health changed.

The Mental Capacity Act (MCA) is legislation that protects people who may lack capacity to consent to their care and treatment. Staff knew how to protect people under this legislation.

People told us that staff were caring, respected their privacy and dignity and encouraged them to be independent.

People told us that staff had a good understanding of their likes, dislikes and changes in their care needs.

People told us that they were encouraged to pursue their hobbies and interests and maintain relationships with those people important to them.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not safe.

There were not always enough staff available to provide care and support to people when they needed it, in order to keep them safe.

Most people received their medicines at the right time and in a safe way.

Risks to people's health had been identified and measures put in place to reduce these risks.

People felt safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents. However one incident had not been reported to the appropriate agency to ensure this person's safety had been protected.

Is the service effective?

Requires Improvement

The service was not effective.

People were not always supported by staff who received appropriate training and supervision.

People and their relatives told us that overall they received good care.

People were supported to maintain their hydration and nutrition. Their health was monitored and staff responded when health needs changed.

Where people lacked the capacity to make their own decisions, assessments and 'best interests' meetings had taken place.

Is the service caring?

Good

The service was caring.

People were treated with kindness, compassion and respect.

People were encouraged to make choices and decisions about their care.

Staff had a good understanding of people's likes and dislikes in relation to the care and encouraged them to be as independent.

Is the service responsive?

Requires Improvement

The service was not responsive.

People did not always receive care and support that met their individual needs and preferences as staff were not always available at the times they needed them.

People told us that any complaints, concerns or issues they raised were not always dealt with, in order to improve the service they received.

Summary of findings

People told us that staff had a good understanding of their likes, dislikes and changes in their care needs.

People told us that they were encouraged to pursue their hobbies and interests and maintain relationships with those people important to them.

Is the service well-led?

The service was not well led.

Systems in place to monitor the quality and safety of the service had not identified a number of shortfalls in relation to people's care and safety. Because of this actions had not always been taken to promote continuous improvement.

The management team sought the views of people who used the service, their relatives and staff. However actions had not always been taken to address issues raised.

Requires Improvement

Western Park View 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.

The inspection took place on 13 and 14 October 2014 and was unannounced.

The inspection team consisted of two inspectors.

Before our inspection, we reviewed information we held about the service. We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

During the inspection we spoke with the registered manager, the regional manager, the deputy manager, five care staff and the cook. We also spoke with three health professionals, seven relatives and nine people who used the service. We observed people during lunchtime, the staff handover and the premises. We looked at the premises due to issues raised at the time of the last inspection.

We looked at care records and other records which related to the management of the service such as training records and policies and procedures. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 2 April 2014 we found that the premises had not been maintained to a standard to ensure people's safety. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that improvements had been made with regard to the premises. For example, redecoration of the home and improved lighting. We did not identify any concerns in relation to the safety of any areas of the premises we inspected.

People who lived at the home, their relatives and staff we spoke with told us they thought there were not enough staff available to support them at the times they needed them. When we observed people in the lounge, we saw two occasions where no staff were present. During this time we observed a person who had been assessed as being at risk of falling, tried to stand up from their chair unaided. People in the separate conservatory lounge also required support from staff to mobilise and there were periods of time where no staff were present. We observed staff entering infrequently, usually to bring another person into the lounge. We observed that staff were rushed and call bells rang for a long time before they were answered.

We spoke with the registered manager about staffing levels. They told us they had reviewed staffing levels since our last inspection in April 2014. They told us that they had increased the number of care staff on duty in the morning as they had deemed this to be the busiest time. They told us that the staffing levels had been determined using an assessment tool based on people's dependency needs. Despite this, however, we found current staffing levels were not always keeping people safe.

This was a breach of Regulation 22 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People we spoke with told us that staff supported them to ensure they received their medicines at the right time. We saw staff administering medications to people in a safe way and medicines were kept secure.

However, we found a small number of gaps on the medication administration records of two people. For one person an anti-allergy medicine had not been administered for a period of five days. We spoke with the nurse on duty about this who said that this was because the prescription of this medicine had not been issued by the GP surgery. This had resulted in the subsequent delay in the person receiving the medication. For another person we saw that they had not received an iron supplement on one occasion. We raised this with the staff on duty who could not explain why this medicine had not been administered. The registered manager told us that additional monitoring of medication records would be put into place to reduce the risk of similar errors from occurring again.

Risk assessments had been undertaken which identified risks to people's health and safety and measures were put in place to keep people safe. For example, we saw that people at risk of developing pressure sores had specialist mattresses and cushions supplied and being used, to reduce the risk of the development of sore skin. We saw that people at risk of falling out of bed had bedrails and bumpers in place to protect them. There were associated risk assessments to ensure these were supplied safely and used correctly. We also saw individual fire evacuation plans in the records so that people's individual risks could be managed in the event of evacuation if there was a fire.

We looked at three staff files and found that robust recruitment processes had been followed, in order to keep people safe.

The provider had safeguarding policies and procedures in place. These were designed to protect people from harm. Staff we spoke with had a good understanding of these and told us they would immediately raise any concerns with their line manager. They told us that they were confident that actions would be taken to address concerns raised.

We saw that appropriate safeguarding referrals had been made, however, during our inspection we noted that on one occasion bruising to a person had not been reported to the safeguarding authority, or to us. We discussed this with the regional manager who agreed this should have been reported.

Requires Improvement

Is the service effective?

Our findings

At our inspection on 2 April 2014 we found that staff had not undertaken all training relevant to their roles, in order to provide care and support to meet people's needs. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that although staff had undertaken some recent training, they had not been provided with training in line with the provider's annual training programme. A visiting health professional told us that staff had not undertaken training about the importance of record keeping. They told us that they had identified shortfalls in relation to the recording of people's fluid intake. We also found this to be the case. Despite this, staff told us that they thought that training provided was good and equipped them to fulfil their job roles. We spoke with the registered manager who told us that additional training had been provided since our last inspection, however recognised that this had not all been provided as yet. The regional manager stated this would be followed up quickly.

Staff spoken with told us they had not received supervision, for over a year, where they could discuss their work and any issues that needed to be improved with their line manager. We saw that some supervision sessions had taken place but these had been carried out infrequently. The registered manager agreed that supervision was needed to be undertaken more regularly in order to support the staff team.

This was a continued breach of Regulation 23 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were complimentary about the food provided at the home. Everyone we spoke with told us that it was hot, varied and to their taste. They said they could have something else if they did not like the meal offered. People were offered drinks and biscuits in between meals.

Relatives told us that they could stay for dinner for a small charge whenever they wanted to. When they had done so, they found the food had been excellent.

We observed staff during lunchtime. They asked if people needed help with cutting up their meals or any other support. We saw staff assisting people in a patient manner. People were enabled to eat independently with the aid of adapted cutlery and drinking utensils.

People were able to sit where they wished and were given a choice of main meal and cold drink.

The cook told us that some people required thickeners in their drinks; some required soft diets other people were diabetic. The cook showed us the list they used to prepare meals and this reflected people's dietary needs.

Staff told us that people were weighed regularly. They told us that if people had lost weight a food and fluid chart was introduced to monitor their intake. However, we saw that records of people's weights and food and fluid charts were not always completed accurately. For example, the care plan of one person who had lost weight stated that this person's weight was to be recorded weekly. Records showed that this had not been undertaken. We discussed this with the registered manager and deputy manager who explained that the hoist weighing machine was sensitive and occasionally recorded incorrect weights. This meant this person had not lost weight as they had previously thought. However, at the time, weight and food and fluid charts were expected to be completed and had not been carried out as directed.

One person we spoke with told us that the district nurse came out to the home at the times they needed. This was further supported from our observations during our inspection. People told us they could see the GP if they were unwell and information in care records further supported this.

Relatives said that they people saw their GP regularly and the district nurse came into the home. On the first day of the inspection one person went for an appointment for a specialist wheelchair. Another person attended an eye appointment. We saw that staff accompanied people to these appointments, in order to provide support during these times. One relative told us that since coming to live at the home their relative's health had improved. This had resulted in a reduction of the person's medication. Another visitor told us their relative had a hearing problem and the care staff had arranged for a hearing aid to be supplied.

Staff spoken with had a good understanding of how to support people with limited capacity to make decisions

Requires Improvement

Is the service effective?

about their care. The registered manager told us that there were Deprivation of Liberty Safeguards (DoLS) authorisations in place. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards set out the requirements to ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves and to ensure that care is given in a person's best interests.

We saw a recent DoLS application they had made to the Local Authority which had been authorised. We looked how the process had been managed and saw that the home's staff had followed the correct procedures. The recommendations of the Local Authority were clearly documented and a plan had been created by the home's staff to work to. We found staff were aware of this plan and it was being followed.

Good

Is the service caring?

Our findings

People were very complimentary about the staff team and said that they were kind and caring. One person told us, "Staff are kind". Another person said, "Staff try their best." The health professional we spoke with told us they had consistently observed that staff were very caring in their relationships with people.

People said that staff respected their choices, for example, one person said, "I like to stay in my bedroom and have all my meals here. Staff told me that was no problem."

People we spoke with said that staff always made sure their dignity was maintained whilst personal care was provided. One member of staff told us that people could ask to be cared for by a male or female carer if they wished. We observed staff hoisting a person from their chair to a wheelchair for lunch. This was completed with consideration and their modesty was maintained. We observed staff knocked on people's doors before entering to promote their privacy.

Most of the relatives we spoke with felt that the care and support at the home was good. One person said, "The home has made such a difference" and another told us that they felt their relative was "much safer here". Most relatives said staff worked hard and their relatives were well cared for. One visitor, however told us that she thought that the attitude of a staff member had been less than helpful when she tried to get help when her relative needed help with personal care. We discussed this with the registered manager who said that they would address this concern.

People we spoke with said that staff were very kind and gave them the care they needed. One person said staff were "excellent." We observed that staff treated people as individuals, asked before tasks were completed and explained things well. We saw that staff had a good understanding of people's needs and knew people's likes and dislikes. All the people we spoke with said that staff were caring and from our observations people were relaxed and had a good rapport with staff.

One person we spoke with told us that they were always involved in decisions about their care and that they could do things "their way". Other people we spoke with were not really sure but said that they were not "fussy" anyway as care and support provided was very good. Care records reviewed further supported that people were involved in decisions about their care.

Within the care records we sampled we saw that people were consulted about their likes and dislikes and their faith. There was a "This is your life" document which recorded people's personal history with details of their occupation, family and information relevant to the support they now required. There was a document that identified their end of life wishes. Records showed that people and their relatives had been consulted and involved with the content of these.

We observed that people were asked if they needed assistance and their independence was promoted. People had walking aids to help them walk independently and adapted cutlery and aids to help them drink and eat independently. We saw that people who could move around the home independently were encouraged to do so. One person liked to spend their day outside and were able to do so. Another person had been for a wheelchair appointment. They told us that adaptations were to be made to their wheelchair to maintain their independence.

All of the relatives we spoke with told us that they were made to feel very welcome and could visit the home at any time. They told us they could have a cup of tea or coffee and could arrange to stay for a meal whenever they wished.

Requires Improvement

Is the service responsive?

Our findings

At our inspection on 2 April 2014 we found that people's care was not always planned and delivered in a way that met their individual care and welfare needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that care was not always delivered in a way that met people's individual needs and preferences because staff were not always available at the times they needed them.

Most people we spoke with told us they thought there were not enough staff available to support them with their personal care needs in a timely manner. They told us that they thought that staff were always very busy. One person told us they usually got up at 9:00am to 9:30am but that staff did not come to help them until 11:00am. Another person told us "I have to wait up to 45 minutes for help to go to the toilet." A visitor told us that they had observed that staff were not always available when people needed them. They gave us an example of how this had impacted on their relative. They told us "At the weekend recently my relative needed to go to the toilet. I told a care assistant but she disappeared and did not come back. I had to go and try and find staff and it took me a long time to find one. This has happened about six times in the past three months."

A number of staff members we spoke with told us that it took up until approximately 11 o'clock in the morning to assist people to get out of bed and provide support with their personal care needs. They told us that this was because they were not enough staff to meet people's preferences of when they wanted to get up. We observed that the morning drinks in one lounge were not served until 11.50 in the morning. Staff said that they had been busy and this is why morning drinks had been late. This meant people could not be assured that staff were available at the times they needed them.

This was a continued breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that any complaints, concerns or issues they raised were not always dealt with, in order to improve the service they received. One person told us they felt staff did not listen to them. They said they had raised two issues with staff and that they felt they had been ignored as the issues had not been resolved. The person's relative also confirmed they had complained about these issues but nothing had been done. We found these issues had not been recorded. We asked staff what they would do if a person made a negative comment about the service. They stated they would record this in the person's daily notes. We discussed this with the registered manager who told us that although the provider's complaints policy was in place, this did not incorporate concerns or more minor issues. This meant that actions were not always taken in response to concerns people raised. Another person who used the service told us "I tell them it takes a long time to get staff to take me to the toilet but nothing gets done. "

We discussed this with the regional manager who told us that all concerns should have been recorded. This was so that they could be followed up and the actions taken could be discussed with the person who raised the concern. They told us that they would take steps to address this issue immediately.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Other people we spoke with told us that they did feel safe and would speak to the staff or manager if they had concerns. One person told us that they had made a complaint about a member of staff and the management team had taken action to ensure this person did not provide personal care to them.

All the other relatives we spoke with said they would go straight to the registered manager or the senior staff if they had concerns. Two people said they had raised issues and they were "sorted now".

People's records showed that their needs were assessed prior to admission to the home. This information was then used to complete more detailed assessments which provided staff with the information needed to plan their care in order to meet their individual needs.

We spoke with three staff about people's preferences and needs. Staff were able to tell us about the people they were caring for and what they liked and disliked. Care plans

Requires Improvement

Is the service responsive?

reflected these and we saw that information had been added to plans of care to reflect people's changing care needs. People told us that their plans of care were reviewed and amended to incorporate changes in their needs.

People told us that the home's staff were responsive in providing care to meet their changing needs. For example one person said they had fallen backwards in their room and banged their head. They said they had now been provided with a wheelchair as their mobility needs had changed. We spoke with three healthcare professionals. They told us the service was responsive in meeting people's care needs and made changes to people's care based on their advice.

Daily handovers took place so that staff could update the next staff team on shift about people's needs and if any changes in their care had been identified. We saw evidence that changes to people's needs were recorded on handover forms to make staff aware. For example we saw it was noted that one person had been awake all night, so staff would take this into account when caring for the person. Staff we spoke with told us the handover was a good source of information.

All relatives said that they were informed of any change in people's health or care. They all told us that communication between themselves and the staff team was good. All said that there had been a recent relative's meeting so issues about the service provided at the home could be discussed.

People told us they had access to a variety of activities and that they could choose how they spent their time. People told us that they were encouraged to pursue their hobbies and interests. One person told us "There is always something going on in the home, I always go downstairs for the entertainment, like the music man." We saw that a range of activities were on offer throughout the week, arranged by staff and external entertainers. We saw staff arrange games for people in the afternoon which involved throwing a ball and throwing rings onto pegs. There was music on in the conservatory and we saw that people were laughing and interacting well with staff in this area.

We saw arrangements were in place to support people to access events outside of the

home. For example, we observed one staff member take a person out for their birthday to meet their family. People told us that they were supported to maintain relationships with people important to them, such as family and friends.

People's faith was discussed and their wishes in relation to this was recorded. People we spoke with said they had attended religious services when they were younger but were not interested now.

Requires Improvement

Is the service well-led?

Our findings

At our inspection on 2 April 2014 we found that improvements were needed in order to assess the quality and safety of service provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sent us an action plan outlining how they would make improvements.

At this inspection we found that further improvements were needed.

Accidents and incidents were recorded and each was analysed individually. However there was no analysis overall to monitor for themes or trends. This meant that measures to reduce the risk of similar accidents or incidents from re occurring were not always put in place and there were limited opportunities for lessons learnt as a result of these.

Quality assurance and audit processes were in place, such as medication audits and care plan audits. However these had not identified the shortfalls we found during the inspection. This showed us that the provider's quality assurance systems were not robust and required improvement to ensure risks were identified so that actions could be taken.

The staff we spoke with told us they were not always provided with good support from the management team.

They said that they had brought issues to their attention such as the lack of staff on shifts and the absence of teamwork between the residential and nursing parts of the home. They said no effective action had been taken to resolve these issues. One member of staff told us, "I have told management about the lack of team work with staff, but nothing seems to have been done about it." Staff were consistent in what they thought were the key challenges faced by the organisation. For example, they said that ensuring better team work especially between day staff in the different wings of the home was needed.

Ensuring the home had a full complement of staff was also another key challenge recognised by staff. Although staffing levels had been increased since our last inspection we saw no plan in place to provide structured timescales to further address these issues. Staff told us improvements were needed in this area.

'Resident and relatives' meetings were held. These provided an opportunity for people to feedback comments or concerns to the management team. However, people told us that not all actions arising from these meetings had been followed up. For example, issues they had raised in relation to the laundry service had not been resolved.

This was a continued breach of Regulation 10, of The Health and Social Care Act 2008 Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Care had not been delivered to meet people's needs and ensure their safety and welfare. Regulation 9 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers There were not effective systems in place to regularly monitor the quality of the services provided and to identify, assess and manage risks relating to the health, welfare and safety of people who used the service. Regulation 10 (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints. Regulation 19 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing People were not supported by sufficient numbers of appropriate staff to meet their care needs and keep them safe. Regulation 22

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that persons employed were appropriately supported to receive appropriate training and supervision. Regulation 23 (1)