Waterfall Nursing Homes Limited

Park Lane Care Home

Inspection report

45 Park Lane
Newport
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Devon
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Park Lane 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. Park Lane can accommodate up to 40 older people who have nursing and or personal care needs. At the time of the inspection there were 36 people living at the service.

The home is divided into two separate units, with people who require nursing care living in one and those who did not require 24-hour nursing care living in the other. Both units had communal rooms on the ground floor and bedrooms on three floors with access via passenger lifts.

Rating at last inspection
At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good, in all areas except safe, which we have now rated as requires improvement. This was because improvements were needs to the way risks were documented and in medicine records. There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns, the areas for improvement were already being mitigated following our feedback. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.
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Why the service is rated Good

People enjoyed living at Park lane. They felt safe and well cared for. Comments included, "If you only want a tissue they will get it for you, they do anything and everything for you, I can't think of a better place." Another said, "I feel well care for, they make us feel special, when it was my birthday they made me a cake, big enough for us all to share, I feel they are here for us and our needs come first." One relative said "They wake mum up with a kiss, she is given hugs when required. There is a person employed to carry out individual pamper sessions, she comes every week she is such a lovely lady." Healthcare professionals said staff were caring. One said, "The have observed the staff during my visits to be polite caring and helpful."

Some improvements were needed in the way in which risks were documented. This was being addressed.

Improvements were needed to records in relation to when staff were applying topical creams. We have made a recommendation in relation to this and to ensure staff administer in line with the prescribed medicines.

Staff knew people well, understood their needs and wishes and worked in a way which showed they were

respecting people's dignity and privacy. There were sufficient staff with the right skills to meet people's needs.

Staff had training and support to do their job effectively. Further training was planned to look at enhancing skills in understanding complex conditions such as diabetes and Parkinson's.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were protected because recruitment was robust and staff understood about abuse and who they should report any concern to.

People's healthcare was monitored and actioned when needed. Their nutritional and hydration needs were met to ensure they maintained weight a balanced diet.

The service was clean and adapted to suit people's needs. Audits and checks ensured quality monitoring of the records, environment and care and support being delivered.

The management approach was open and inclusive. There were and a range of ways used to gain the views of people, relatives and staff.

Further information is in the detailed findings below

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 has changed to Requires Improvement.

Improvements were needed to the way some medicines were being recorded.

Some improvements were needed in the way in which risks were documented. This was being addressed.

People were protected because recruitment was robust and staff understood about abuse and who they should report any concern to.

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service remains Good

Is the service responsive?

Good

The service remains Good

Is the service well-led?

Good

The service remains Good

Park Lane 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.

The inspection was completed on 5 December 2018 and was unannounced. It was completed by one adult social care inspector, a pharmacist inspector, a specialist advisor, who was a nurse in older people's care and an expert by experience. An expert by experience is someone who has had direct experience or their relative had used registered services such as care homes.

Prior to our inspection, we looked at all the information available to us. These included notifications sent by the service, any safeguarding alerts and information sent to us from other sources such as healthcare professionals. A notification is information about important events which the service is required to tell us about by law.
We also reviewed the service's Provider Information Return (PIR). This is a form that is completed at least annually. It asks the provider to give some key information about the service, what the service does well and improvements they plan to make. During the inspection we spoke with 12 people. However, some other people were not able to comment specifically about their care experiences, so 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 living with dementia. We also spoke with three relatives. We spoke in depth to the registered manager, deputy, activities coordinator, two nurses, six care staff, one housekeeping staff, maintenance person, and two kitchen staff. We received feedback from six healthcare professionals.

We looked at four care files including risk assessments, care plans and daily records. We reviewed 12 medicines records, three recruitment records and a variety of records relating to the auditing of the environment and quality of care.

Requires Improvement

Is the service safe?

Our findings

At the last inspection this key question was rated as Good. At this inspection the rating had changed to Requires Improvement. This is because…

We saw that arrangements were in place for the safe storage of medicines including those that require temperature controlled storage and those that require additional security.

We observed the administration of medicines to three people. Although staff administered medicines in a safe and thoughtful manner, medicines were not always given in accordance with the prescribed instructions. For example, dispersible aspirin was not dissolved in water before administration and two medicines were administered together when one was prescribed to be taken preferably 30 minutes before breakfast, caffeine containing liquids or other medications. Since the inspection, the registered manager has informed us that their on line training did cover non oral prescribed medicines. Staff we spoke with at the time of our inspection were not aware it had been covered.

We recommend that medicines are administered in accordance with the instructions on the prescription and dispensing label.

Records of administration of these medicines were made at the time using an electronic system. We looked at the medicine administration records for seven people. Records were complete, and all medicines were available for administration. Records indicated at each medicine round which medicines were due and these also stated for the time and date of the last dose given for "when required" medicines.

People had medicines prescribed to be taken "when required". Care plans contained information about the condition the medicines were prescribed for and sufficient detail of actions and assessments that needed to take place before administration. When these medicines were administered an electronic record was made of the reasons for administration.

Staff had completed Mental Capacity Act and Best Interest medicine documentation for people who lacked the mental capacity to make decisions about their medicines. These had been signed by the relevant people. A pharmacist had checked to make sure that the medicines were safe and effective when administered covertly (given to people without their knowledge often mixed with food and drink). Only the medicines listed were given covertly;

Records were made on a separate paper chart for those medicines such as creams, ointments and sprays which were used as part of personal care. There were body maps available showing where these items were to be applied. These were not consistently completed. There was no impact, in that people's skin was not compromised, which would indicate staff were consistently applying topical creams but not always recording that this was being done. The registered manager said their own audits had highlighted this and was being discussed via supervisions and handovers.

The service had arrangements in place to use Homely Remedies. These are medicines that can be bought over the counter for the treatment of minor illnesses. These medicines were available to be used and there were clear records when they had been used.

Staff who administered medicines had received training. We were informed that they had undergone competency assessments in the handling of medicines but this had not happened since the new electronic system had been installed. The carers on the residential unit had received training in the oral administration of medicines but not by any other routes. They were able to refer to the nursing staff if they had any queries in respect of medicines.

Not all risks had been clearly identified or planned for with people's individual care plans. These included
- No specific epilepsy plan for one person who had this condition
- Lack of detail within care plans and risks for people with diabetes. For example, no indication of what was their normal ranges
- For people using oxygen, no detail within risk assessment about cleaning and changing of equipment

When we fed this back to the registered manager they said in respect of people with diabetes, "There are clear instructions on the non-structured PRN's for hyperglycaemia, for our insulin controlled diabetic. The two diabetic residents (residential residents) who are controlled by medication, we have liaised with the District nurse (D/N) and Diabetic nurses to provide us with the details of individual therapeutic ranges and clear instructions of what to do if residents rise above this. We concluded that this risk was therefore fully covered.

Where people had oxygen, there were clear protocols in respect of cleaning. The registered manager said, "The changing of consumables on oxygen concentrators is a weekly task undertaken on a Thursday night by our night staff this is documented on our weekly night responsibility sheets."

For the person with epilepsy, the service agreed a seizure care plan was needed and this was implemented. This ensured that staff knew the risks and what to do should the person have a seizure. There were sufficient staff for the number and needs of people living at the service. This included always having one nurse on duty, but usually two for most of the day, plus up to six care staff, housekeeping staff, two activities coordinators, two kitchen staff and a maintenance person. The registered manager worked weekdays and the deputy covered some weekends and weekdays. Staff confirmed that without sickness, staffing levels were sufficient to meet people's needs. People said their needs were being met in a timely way. One person said, "I feel safe knowing there is always someone here, I press my personal alarm, there is someone here all the time." Another said, "if we go out they want to know the details, they log when we go and when we come back, it's like a family, you count." A relative said "I feel mum is safe here, nobody is left sitting, everyone's needs are met."

People were protected because the service had a robust recruitment process. This meant new staff were only employed once all the checks and references had been obtained to ensure they were suitable to work with vulnerable people.

Staff understood what abuse was and who and when they may need to report any concerns. Staff confirmed they had completed on line training in understanding abuse and that there were policies and procedures they could access if needed. The registered manager understood her role in the safeguarding process. There had been three safeguarding alerts in the last 12 months. These were alerted by the service who worked with the local authority to ensure people were protected. Two were minor in nature and one was concerning possible abuse from someone outside of the service.

A concern had been raised in June 2018 respect of the moving and handling of one person by a healthcare professional. The service was asked to ensure they worked with the occupational therapist educator to ensure best practice was being followed. This included ensuring care plans in relation to people's moving and handling needs were detailed and included specific instructions to keep people safe when moving them. This action was still not progressed at the time of our inspection. A meeting had been set up to move this forward for 12 December 2018. We found some moving and handling plans included the support needed, but did not include type of hoist or sling. Staff were aware of what equipment and slings were needed for each individual, but lack of documentation around this could lead to an increased risk.

Following feedback, the registered manager wrote to us to explain all their slings were person specific, but some some names had faded on slings. These have now all been remarked. All hoists were clip compatible therefore the type of hoist was not really required.

We recommend that moving and handling plans follow best practice as detailed by the HSE Safety domain- 'Getting to grips with hoisting people.'

Emergencies were planned for. For example, people had individual evacuation plans in the event of a fire. Regular fire safety checks were being done, including testing of alarm bells. Fire equipment such as extinguishers had been serviced and maintained on an annual basis.

The service was clean and free from odours. There were good measures in place to ensure infection control processes were followed. This included a policy in respect of staff making sure they did not wear nail polish or wrist jewellery. We did see some staff had not adhered to this policy. The registered manager said she would ensure the policy was reiterated to staff at each handover meeting. The housekeeping staff had detailed cleaning schedules. Staff had a plentiful supply of protective equipment such as gloves and aprons. They were observed using these appropriately during the inspection.

The provider information return (PIR) stated that for their future were implementing electronic record keeping "we are also planning on lead roles for individual members of staff such as infection control lead, palliative care. Improvement of our pendant call bells to call for assistance from longer distance e.g. garden. To continue to keep up to date with current trends. We have commenced updating DBS's for our longer standing employees, we plan to ensure all DBS's are no older than 3 years old. Extended health and nutrition training is also planned for our chefs." This meant risks and care plans would be revised by champions with specific roles, which should improve the information provided.

Accidents and incidents were being monitored for trends and where patterns had emerged, measures put in palace to reduce risks. For example, risk of falls for people not using their walking aids, staff were asked to ensure tense were visible and near to people.

Good

Is the service effective?

Our findings

The service continues to be effective

People and their relatives said care and support was effective to their needs. One relative said for example, "mother is prone to urinary tract infections. Staff respond quickly, they are on the ball, they monitor her, if she is not eating they give her supplements." One person said, "they are always quick to help me when needed."

Healthcare professionals said the service were knowledgeable concerning people's healthcare needs. One said "I discuss incontinence issues of the home with a senior member of staff who is knowledgeable about the residents and what products they are receiving by having good communication. The paperwork is updated and the correct products are requested, we also discuss pressure areas. I have found the home friendly and very clean and drinks and care given to the residents within their care." One GP practice gave the following feedback "As a practice we have worked with Park Lane for many years and have a number of patient's resident there. We are not aware of any issues nor have any concerns in relation to them being safe; effective; caring; responsive to people's needs and well-led. With regards to requesting medication and repeat prescriptions they appear well organised and work well with us. With regards to contacting the practice they do this appropriately and in a timely manner regarding visits, queries, sharing information etc. We liaise each year with regards to flu vaccinations and provide them with vaccines."

However, one healthcare professional felt the service were not always working in conjunction with them in training and developing best practice. We fed this back to the registered manager who said there had been some miscommunication, but they were now working in conjunction with the professionals to plan training sessions for staff. The health care professional who gave this feedback, confirmed better relationships were now in place. Another nurse educator said "I have always found the staff to be open and engaging in training sessions the cancellation rate is relatively low in comparison to other services. The number of staff attending Care Home Team training session in relation to the number of staff employed by the service is low."

Staff confirmed they had good opportunities for training and support to do their job effectively. This included all aspects of health and safety as well as more specialised areas concerning specific health conditions. This included bowel care, sepsis, hydration and nutrition.

Staff new to care were offered and encouraged to complete the Care Certificate. This is a national set of standards which helps new staff to understand the principles underlying good care. In addition, new staff were given opportunities to shadow more experienced staff until they were familiar with the running of the home and the systems being used.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where

people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

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 made applications to the DoLS (Deprivation of liberty safeguarding) team but none had been authorised yet.

Some people's plans stated they had lasting power of attorney in place, but their files did to have copies of these, the registered manager said these were kept separately and they would always seek to obtain a copy when people were admitted into the home.

Care staff had received training in the MCA and had a limited understanding of how this worked in process. Nursing staff were more knowledgeable about the process. All staff understood the importance of ensuring people's consent was sought and they worked in the least restrictive way. Best interest decisions had been discussed when needed, such as use of bedrails. This was usually documented within the daily notes, but the registered manager agreed this should be more clearly detailed within the MCA section. This would be addressed with the introduction of electronic care plans.

People were supported to ensure their nutritional and hydration needs were met. Where people had been assessed as being at risk of poor nutritional and or fluid intake, staff closely monitored their daily intake. People's weights were monitored weekly and monthly and where weight decrease had been significant, the staff team referred the person to their GP. Some people had been prescribed supplementary drinks to help maintain good calorie intake. We saw some people had lidded beakers in their rooms, but their plans did not indicate these were needed. The registered manager said that some people had requested these as part of their night routine as they were fearful of spilling their drink. She said she would amend their night care plan to show this as their choice. Two people waiting a long time to be assisted with the meal. The registered manager said this was unusual and she would review staff availability at mealtimes to ensure there was enough staff to assist people.

People were offered a choice and wide variety of meals and snacks throughout the day. One person did not like either of the main meal options on the day we inspected and so was offered a sandwich or yogurt. The kitchen staff said they could have also been offered a baked potato, omelette or a selection of sandwiches. They said they were flexible and tried to accommodate everyone's tastes.

Park lane had been adapted to suit the needs of frail elderly people, some of whom were living with dementia. For example, a lift was available to access upstairs rooms. Rails and grip bars were positioned so people with mobility issues could move around. Toilets were well sign posted. There was a variety of seating available to suit people's differing needs. Specialist equipment including hoists were available for those who needed support to safely transfer.

Good

Is the service caring?

Our findings

The service continues to be caring

People said staff were caring and kind towards them. For example, one person said, "If you only want a tissue they will get it for you, they do anything and everything for you, I can't think of a better place." Another said, "I feel well care for, they make us feel special, when it was my birthday they made me a cake, big enough for us all to share, I feel they are here for us and our needs come first." One relative said "They wake mum up with a kiss, she is given hugs when required. There is a person employed to carry out individual pamper sessions, she comes every week she is such a lovely lady." Healthcare professionals said staff were caring. One said, "I have observed the staff during my visits to be polite caring and helpful."

People said staff upheld their dignity and respect. For example, they said their door would be shut and curtains drawn before any personal care activities are carried out. One person said, "I have had diarrhoea twice, I was embarrassed, they were kind to me and told me not to worry and that is what they are here for." Staff were able to describe ways in which they worked to ensure people's privacy and dignity was considered at all times. Our observations showed this worked in practice. For example, when one person was being hoisted, staff took time to adjust their clothing to ensure their dignity was upheld.

People were afforded choice about where they wished to spend their time and staff encouraged independence as far as possible. Care plans described what personal care people could do for themselves and what support they needed. This helped to give people their independence.

Staff knew people well, what and who was important to them. Our observations showed people had good relationships with staff, felt comfortable with them and there were friendly and warm exchanges throughout the day. Staff made visitors welcome, knew who they had come to see and offered drinks and snacks. Visitors said they could visit at any time and were always made welcome.

People's rooms had family mementos and personal touches such as photographs and books and ornaments, giving them a homely feel. People and relatives confirmed they could visit at any time, were made welcome and offered refreshments. People could choose to see their friends and families in the privacy of their room or a communal area if they wished.

The service had received many thank you cards detailing the caring and compassionate nature of staff. Comments included "Thank you for all the kindness and care you gave to (name of person). It was very much appreciated and gave us confidence to know she was being so well looked after." And "thank you for making their time here so special, you really looked after her with such caring and compassion."

Good

Is the service responsive?

Our findings

The service continues to be responsive

People felt the service and staff were responsive to their needs and wishes. One person said "I can ask for anything, the staff are great. Very helpful." Another person who spent most of their time in their room said staff were attentive and did check on them on a regular basis. They said their call bell was answered promptly.

People's care and support was well planned. This was because prior to admission a pre- admission assessment was completed. This information was then used to develop a care plan to inform staff how to provide care and support in all aspects of people's needs. We did not see evidence of these plans being shared or reviewed with people or their relatives. The registered manager said that the daily records would should plans had been discussed with people, but would address identifying this more clearly when they introduced their electronic care planning system in the new year.

The service employed two activities people to help people enjoy a variety of interests and hobbies. This included group sessions such as music, paid entertainers, art and quizzes. It also included some one to one activities with people in their own room. The provider information return stated "Staff are trained to give personalised and timely care, staff will familiarise themselves with each resident to know them well, their life histories and what is important to them. The level of care given aims to promote every residents' health and well-being to enhance their quality of life. We encourage our residents to socialise and continue with previous hobbies and interests and continue outside friendships."

Some people were enabled to access the local community to visit their church, go out for coffee and meals out. They were also looking to get more people out to places of interest, shopping and visiting the local garden centre. Moving forward Park Lane want to do more inter-generational activities having had two successful placements for students doing some work at Park Lane towards their Duke of Edinburgh award. To this end they had appointed two community champions to work with groups such as the local scout group.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans included when staff needed to consider people's sensory or hearing impairment. Staff were able to communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. Areas of the service were sign posted with pictures, for example toilets, to help people find their way.

Complaints and concerns were taken seriously. There was a written complaints policy and people said they would be confident to make their concerns known. For example, one relative told us they had approached the provider following the removal of a small settee in the lounge area. She said that it had been a favourite

settee for her as she was able to sit on it and cuddle her mother. The provider acknowledged her comments and a new settee was promptly provided. One person said that problems they had experienced with their TV and bathroom fittings had been promptly addressed by the handyman.

End of life care was seen an important part of staff role. Staff had some training in working with people at end of life care. For people who were on the nursing unit, the service own nursing team managed people's pain. Where people were did not having ongoing nursing needs and were therefore part of the residential unit, the community nurse and hospice nurse team provide ongoing support. The provider information return stated they work closely with the local hospice and advance care plans were adhered to when in place. They ensured they discreetly indicated to other staff when a person had passed away a small angel is placed on the desk in reception, this way staff members coming onto shift could discreetly enquire as to who has gone. They also compiled a "What to do next booklet" for relatives to take away with information and contact numbers on how to obtain death certificates and registering deaths etc.

Good

Is the service well-led?

Our findings

The service continues to be well-led

The registered manager and senior team worked together to provide strong leadership to the staff team. The vision and values of the service were to ensure people received safe, compassionate care in a homely environment. Staff understood these values and worked in way to show they were upheld. People's needs and their views were paramount and these were fully considered when making any improvements to the service. The provider information return said "With recent additions to the activities team we are hoping to hold more residents' meetings to ensure their social needs are met. We have launched a new website with a live calendar, which displays for residents and relatives ongoing activities."

Staff felt valued and listened to. They said there was a good team work approach and the registered manager had an open-door policy. Training and support were key to ensuring quality outcomes for people. Staff views were regularly sought via handovers, meetings and through supervisions. The PIR gave examples of how staff were valued. Recently following feedback pre-supervision questions were given to guide management to ensure staff feel valued and appreciated for their work. Staff surveys were completed and an individual cupcake was given from management with individualised cards to make staff feel appreciated, this included a gluten free cake for a staff member with an intolerance to gluten.

The provider used various ways to gain the views of people and their families. This included annual surveys, meetings and one to one discussions. There was evidence of staff meeting with people to discuss their ideas and suggestions for improvement. For example, reintroducing sofas for people to cuddle their relatives on following feedback from relatives.

There was a range of audits and checks to ensure records and the environment was kept safe and clean. For example, the housekeeping staff had check lists of daily and weekly tasks, which included monthly deep cleans of each room. Checks were completed on hot water temperatures and window restrictors. The maintenance person checked what services and contracts were needed to keep the environment safe and well maintained. This included fire safety, gas and electrical certificates.

It was clear there was good partnership working with GPs, local authorities and community nurses. The service had also ensured they had a community presence with their fundraising events and links with local schools. They had invited local neighbours for a cup cake and coffee event and a glamourous granny event.

The manager understood their responsibilities to act in accordance with regulation and to report any significant events and notifications.

The rating from the last inspection report was prominently displayed in the hallway of the service and on the provider website.