Care Quality Commission

Key inspection report

Care homes for older people

Name:	Partridge Road Care Centre
Address:	Partridge Care Centre Partridge Road Harlow Essex CM18 6TD

The quality rating for this care home is:	one star adequate service

A quality rating is our assessment of how well a care home is meeting the needs of the people who use it. We give a quality rating following a full review of the service. We call this full review a 'key' inspection.

Lead inspector:	**Date:**							
Jane Greaves	1	3	1	0	2	0	0	9

This is a review of quality of outcomes that people experience in this care home. We believe high quality care should

- Be safe
- Have the right outcomes, including clinical outcomes
- Be a good experience for the people that use it
- Help prevent illness, and promote healthy, independent living
- Be available to those who need it when they need it.

The first part of the review gives the overall quality rating for the care home:

- 3 stars - excellent
- 2 stars - good
- 1 star - adequate
- 0 star - poor

There is also a bar chart that gives a quick way of seeing the quality of care that the home provides under key areas that matter to people.

There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

We review the quality of the service against outcomes from the National Minimum Standards (NMS). Those standards are written by the Department of Health for each type of care service.

Copies of the National Minimum Standards – Care Homes for Older People can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The mission of the Care Quality Commission is to make care better for people by:

- Regulating health and adult social care services to ensure quality and safety standards, drive improvement and stamp out bad practice
- Protecting the rights of people who use services, particularly the most vulnerable and those detained under the Mental Health Act 1983
- Providing accessible, trustworthy information on the quality of care and services so people can make better decisions about their care and so that commissioners and providers of services can improve services.
- Providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money.

Reader Information

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Information about the care home

Name of care home:	Partridge Road Care Centre
Address:	Partridge Care Centre Partridge Road Harlow Essex CM18 6TD
Telephone number:	01279452990
Fax number:	01279452995
Email address:	admin@rushcliffecare.co.uk
Provider web address:	

Name of registered provider(s):	Rushcliffe Care Ltd
Name of registered manager (if applicable)	
Christine Stacey	
Type of registration:	care home
Number of places registered:	117

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
dementia	117	0
old age, not falling within any other category	0	117
physical disability	117	0
sensory impairment	117	0

Additional conditions:

1. The registered person may provide the following category/ies of service only:Care home with nursing - Code N to service users of the following gender: Either whose primary care needs on admission to the home are within the following categories: Old age, not falling within any other category -Code OP Dementia - Code DE Physical disability - Code PD Sensory Impairment - Code SI. The maximum number of service users who can be accommodated is: 117

Date of last inspection								

Brief description of the care home

Partridge Care Centre is part of the Rushcliffe Care Group and is located in Harlow, Essex.

Brief description of the care home

The home opened in May 2009 and provides care and support to a total of 117 people with varying needs.

The centre is modern and purpose built comprising the Kingfisher Suite and the Mallard Suite. Kingfisher specialises in Care of the Elderly, including those individuals with Dementia. The Mallard Suite offers round-the-clock Specialist Nursing Care for adults who require highly specialised neurological, physical disability, Challenging Behaviour and for those presenting with complex nursing needs who may require access to the Multi Disciplinary Team. The Mallard suite has specialist facilities such as a Hydrotherapy pool, a Gymnasium and Full Tracking systems in most rooms for safe handling of clients.

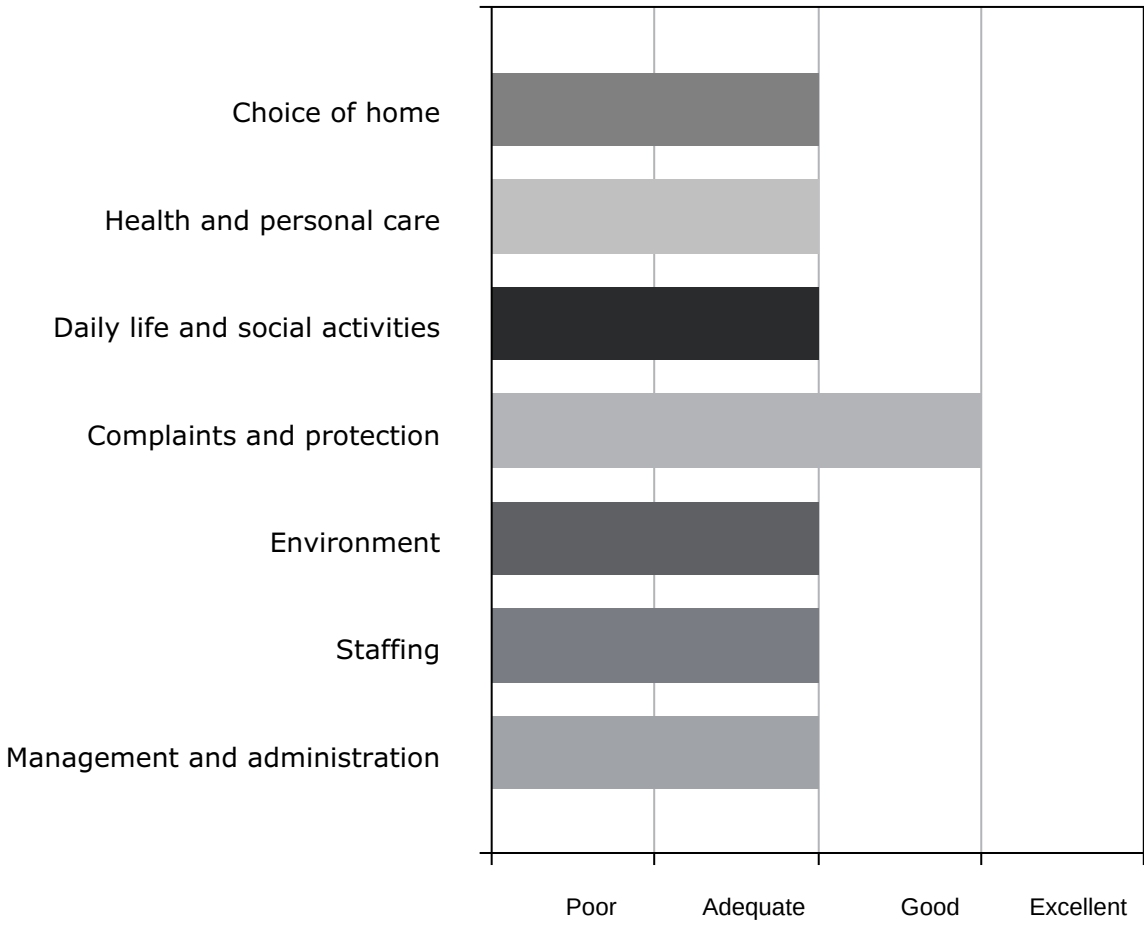
Each unit has it's own large lounge/dining area and kitchen. There is also an activities room and a hairdressing room The fees are negotiated dependent on care needs. There is ample parking on site for visitors to the home.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	one star adequate service

Our judgement for each outcome:



How we did our inspection:

This was an unannounced key inspection site visit undertaken over 2 days.
At this visit we considered how well the home meets the needs of the people living there and how staff and management support people.
A tour of the premises was undertaken, care records, staff records, medication records and other documents were assessed. Time was spent talking to, observing and interacting with people living at the home, visitors and staff.
Prior to the site visit the manager had completed and sent us the home's Annual Quality Assurance Assessment (AQAA). This is a self assessment document required by law and tells us how the service feels they are meeting the needs of the people living at the home and how they can evidence this.
Before the site visit a selection of surveys with addressed return labels had been sent to the home for distribution to residents, relatives and staff. Views expressed by visitors to the home during the site visit and in surveys responses have been incorporated into this report.

The registered manager was not present throughout this inspection visit however did attend the service to receive feedback and have the opportunity for discussion and clarification after the first day. Feedback on findings was provided to the deputy manager throughout the inspection.
We would like to thank the residents, the management, the staff team and visitors for the help and co-operation throughout this inspection process.
This was the first Key Inspection of this service that was first registered in May 2009.

What the care home does well:

Partridge Road is a large, modern and spacious building that was very clean and clear of malodours.

Residents and relatives praised the staff team for being caring, friendly and kind.

The staff members demonstrated good knowledge of how each person preferred to be cared for and supported.

People enjoyed the food at this home.

What has improved since the last inspection?

This is the first inspection of this service since registration in May 2009.

What they could do better:

Whilst it is clear that the manager and team have worked hard to develop this service since registration there is still some work to do around needs assessments, care planning, daily recording, staff training, health and safety and medication daily practice and these shortfalls have, unfortunately, affected the rating of the home.
The manager needs to continue to develop the staff team so they all have a person centred approach to care and residents' abilities and independence is recognised and optimised in all they do.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details on page 4.

The report of this inspection is available from our website www.cqc.org.uk.
You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line 0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them and the support they need. People who stay at the home only for intermediate care, have a clear assessment that includes a plan on what they hope for and want to achieve when they return home.

People can decide whether the care home can meet their support and accommodation needs. This is because they, or people close to them, have been able to visit the home and have got full, clear, accurate and up to date information about the home. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between them and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Information gathered prior to people being admitted to the home was not always detailed enough for people to be assured their individual care and support needs would be met.

Evidence:

We received 12 completed surveys from people living at the home. All indicated they had received sufficient information about the home, prior to moving in, to make an informed decision.

We looked at the home's Statement of Purpose and Service User Guide, these were detailed and clearly described that facilities and services provided.

The Statement of Purpose stated 'Prior to admission the Registered Manager (or designated person) from Partridge Care Home will carry out an 'Assessment of Need'.

Evidence:

A prospective Resident will only be accepted if the manager feels confident that the Unit can adequately meet those needs'.

The manager's AQAA stated that 'Information gathered before admission includes; 'Initial Enquiry Form', which allows the staff to receive basic information needed to decide if the enquiry should progress further, placing authorities 'Care Plan', and/or 'Decision Support Tool'; also for those who are privately funded. All prospective residents are invited to spend time in the Home as part of the assessment process, and overnight stays are an option where feasible. Not all individuals who approach the home for assessment are actually admitted. If we think we cannot meet the individual's needs or expectations, then we would decline admission, giving our reasons for this'. The deputy manager told us that the usual course of events was that they received phone call from Social Services to discuss a potential admission, then received a faxed copy of the Social Services assessment of need document and then arranged to visit the individual in person to undertake a full assessment of needs.

We looked at care documentation for 3 of the 31 people living at Partridge Road Care Centre. This showed there was a pre admission assessment procedure in place to ensure that the staff team were able to meet prospective residents' needs.

These documents showed that information was gathered from the ward staff at the hospital and family members. The assessment of needs document completed by representatives from Partridge Road Care Centre varied considerably in the amount and quality of the information recorded. For example, on one file we looked at the information about one individual's likes and dislikes around eating and drinking included a tick in a box to indicate the person had a small appetite and a comment 'likes tea'. This person had a diagnosis of dementia, in the section of the assessment form relating to cognition the assessment was summed up by the narrative 'confused'. The care plan was signed to show that the person's family had been involved with this assessment. We spoke with the relatives, they told us that they had been caring for their relative for a number of years prior to them moving into the home. They had a wealth of knowledge about the individual's likes/dislikes, preferences and choices to help the home understand this person and yet little information had been documented during the assessment process.

Assessments did not include information about peoples' strengths, levels of independence or skills. This means that staff would not have the information necessary to promote peoples' independence to enhance their quality of life.

The deputy manager said sometimes a letter was sent to prospective residents

Evidence:

confirming their placement at the home and assuring them that the home could meet their assessed needs. He demonstrated an awareness of the need to do this however acknowledged that not all residents received this confirmation.

People told us they were shown around the home to help them choose an appropriate care setting for their relative. One relative told us that they had experienced a stressful time coming to terms with their relative having to move into a care home but they had found the staff and management at Partridge Road Care Centre to be very supportive and caring during this difficult time.

Another relative told us 'We took our relative to the home to look around, the deputy manager did the needs assessment then. He was very thorough and nice with X'

Health and personal care

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's health, personal and social care needs are met. The home has a plan of care that the person, or someone close to them, has been involved in making. If they take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it, in a safe way. People's right to privacy is respected and the support they get from staff is given in a way that maintains their dignity.

If people are approaching the end of their life, the care home will respect their choices and help them feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People can generally expect their health needs to be addressed but some shortfalls in care planning mean that their independence and dignity is not always promoted.

Evidence:

We looked at care plans relating to three people living at the home. There was a full medical history for each person and a record of health care professional involvement including the outcome of these. There were records to show that peoples' weights were being monitored and nutritional risk assessments were in place. None of the plans we looked at included a photograph of the person as required under regulation. There was a document titled 'getting to know you'. This was given to families to complete to create a pen picture of the person's previous life, loves, relationship, previous occupation etc.

Care plans were in place for areas such as personal hygiene, activities of daily living, social recreational and meaningful activity, medication, diabetes and sleeping. One file we looked at included an assessment of 'mouth care protocol' about the care of teeth, gums, dentures and lips. The evaluation produced a score of 11 which indicated that

Evidence:

intervention was required. The monthly evaluation for September and October stated that the person continued to need intervention with oral hygiene. The person's care plan stated 'to assist X with oral hygiene' but there was no clear instruction for care staff to follow to ensure this person's specific need or needs were being met. Daily records stated the person had been 'assisted with all their personal care'. This did not provide enough evidence for people to be confident that this individual's specific needs were being met. One healthcare professional we spoke with told us that, in some instances, oral hygiene practice in the home was 'pretty bad'and this had resulted in the need for medical intervention.

Another care plan we looked at stated that the person 'needs assistance of one carer to maintain personal hygiene and oral care'. Extracts from the care plan included: 'Allow X to choose what they want to wear' 'Give bath once a week', 'Brush and groom hair'. There was no detail about how the person may wish to be supported and no person centredness to this care plan, it reflected a list of tasks that needed to be done. There was nothing recorded in the monthly evaluations to indicate that the care plans had developed since the person was first admitted to the home and as staff got to know them better. Staff we spoke with acknowledged that they held a lot of knowledge in their heads about how people liked to be cared for and that this was not always reflected in the care plans.

One person's file we looked at contained 2 care plans relating to personal hygiene. Staff told us the original plan was not clear so it had been re-written however the information had changed with different detail of how the person wished to be supported. For example, one care plan said 'give bath once a week', the second version said to offer bath/shower or strip wash each morning. There was no evidence that evaluations informed changes to the care plans where changes had been made.

We saw examples of daily recording on the nursing unit that indicated tasks undertaken as opposed to how people had been cared for and how their individual care and support needs had been met. Examples included 'ate and drank fairly well', 'toileted as needed'. We noted that daily records on the residential unit were more holistic than on the nursing unit, they described peoples' demeanor and how people had spent their day.

The deputy manager told that monthly care plan audits were undertaken to identify any shortfalls in this area. We saw evidence of one of these audits, this showed us that the management was taking a pro active role in care planning however, the audit identified a number of areas of shortfall and the system had not been in place for long enough to show us any sustained improvement in this area. The deputy manager

Evidence:

provided staff with written feedback from the audits with action plans to be completed within timescales. The deputy manager told us that a similar system was to be implemented with regards to medication audits and this was due to have taken place on the day of this visit. The home has been operating for five months and audit systems are only just being implemented at the home.

The care plan audit of 10th October was seen. Areas that were identified in the audit included no photograph of individuals, signatures and dates missing, some care plans overdue for review and some social activities care plans missing. An action plan had been developed from this audit with named people responsible for taking actions to address the identified shortfalls.

The manager's AQAA stated in the 'What we could do better' section: 'Ensure that we conduct and document a thorough assessment of each Resident's abilities and needs during the first 72 hours after admission. Following assessment compile Individual Care Plans. These care plans will then be discussed with the Resident or their relative/representative, and refined based on their wishes/views. When the care plans have been agreed, they should be signed by the Resident or relative/representative.' This showed us, together with the care plan audit undertaken, that the management is aware of some of the shortfalls in the care planning and recording and are taking action to bring about improvement.

Nine of the 12 people responding via surveys said they always received the medical care they needed, one said usually, one said sometimes and one did not have an opinion.

During our inspection visit a visitor asked staff to confirm if transport had been arranged to take their relative for a pre arranged hospital appointment. It transpired that the the service had been given 3 weeks notice of this hospital appointment and that the resident would need hospital transport to be arranged for them. The letter was eventually located in the communication book in the back of a drawer in the nurses station. Transport was immediately arranged but this was an example of a communication breakdown that would have meant the resident would not have had transport to take them for a healthcare appointment.

Whilst taking a tour of the home on the first day of this visit we saw that the morning medication was still being administered at 10:15. The Medication Administration Records (MARs)indicated that the medication was given at 08:00 hrs. The charts indicated that the next round of medication was due at 14:00hrs however this actually took place at approx 13:00hrs after lunch had been served (12:30) This meant that,

Evidence:

in some instances, there was barely 3 hours between medication rounds. Not only did the charts not effectively provide a clear record of when people had received their medication there was a risk that peoples' medication doses may be administered too close together. In order to be sure that peoples' health needs are being met there is a need to have clear records to show that medication is given at the time specified on the prescription. In the main the MARs were initialed by the qualified staff to indicate when they had administered peoples' medication however, one person's records we looked at were not initialed for their 10pm medication the day prior to this visit. Staff on duty checked the stocks of medication and confirmed to us that the person must have been given their medication but the staff on duty had not signed to confirm this. Inaccurate recording means that it was not possible to be certain when people had been given their medication.

We saw that many of the MARs did not include a photograph of the resident. These would help staff to check the identity of residents before administering their medication to prevent errors.

Medication was stored in locked trolleys in locked treatment rooms. On the ground floor residential unit we saw that boxes of medication were not dated when they were opened, this meant there was not an effective audit trail of the medication held at the home. On the upstairs nursing unit all medication sampled was dated to say when it was opened.

Some medications need to be stored in a fridge. We saw that the records of monitoring the temperatures of the medication fridge in the residential unit were inconsistent. The entry prior to this date(12th October) was 24th September. This means that people cannot be confident that these medications are stored at the correct temperature. The medication fridge temperature records on the nursing unit were more regular than ground floor but still gaps remained.

We saw there was a secure storage facility for controlled drugs (CD) in each treatment room on each floor. At this time there was one CD register held in the ground floor treatment room. We checked all the controlled medication held for people living at the home and these balanced and agreed with the register.

Staff told us that some equipment necessary to help them meet peoples' needs was not readily available at the home. This included bed pans, urine bottles, slings, sliding sheets and dressings. We discussed this with management, they told us they did not feel this was the case, and that all items needed were requested immediately. It was acknowledged that there was a time delay between the request being made from the

Evidence:

floor, being passed onto Head Office, the items being secured and then being received at the home.

We saw individual 'needs charts' for all residents living on the nursing unit in a pile on the window ledge in the communal lounge/diner. These included very personal detail such as 'bottom really red and sore'. Other information included detail of what food individuals had eaten, had they had their incontinence pad changed or if they had their bowels open. This does not serve to promote the dignity of individuals as these records were available for anyone visiting the unit to read.

Observation on both units was that residents appeared to be happy and well cared for however, some personal care issues were noted on both days of our inspection. We saw that some of the ladies living at the home were not provided with the support to attend to personal grooming. One care plan we looked at stated 'Aim is for staff to support xx with a high standard of personal hygiene, to promote self care and dignity'. Some family members we spoke with as part of this inspection process told us their relative had always been very well presented and always looked after their personal grooming as a younger person. This was an area in which they felt their relative could be supported better, our observations on the day regarding peoples' hair, clothing and other aspects of personal grooming confirmed this.

Daily life and social activities

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives. They are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. People have nutritious and attractive meals and snacks, at a time and place to suit them.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People cannot be sure they will lead a fulfilling lifestyle or that the routines of the day are always resident led. People generally enjoy the food they are provided with.

Evidence:

The manager's AQAA included the following statements. 'Gather information regarding the Residents to include all aspects of their life. Offer choice in all aspects of their daily life. Dedicated staff support with recreation and social activity. Staff routines are flexible to meet the needs of the residents, and are reviewed on a regular basis. The importance of respecting individual Residents human rights, dignity and choice forms part of staff induction and training. Visitors to the Home are made welcome, and any restrictions regarding visiting are in-line with health, safety and security'.

In completed surveys sent to us prior to this visit one person said they always have activities to take part in, 3 said usually, 5 said sometimes, 1 said don't know and 2 said never. Comments in the surveys included: 'More activities would be nice' and 'They could arrange various activities (For those that are able) to structure the week. Ie Bingo, quizzes, gentle exercises, maybe social gatherings for an hour in the evenings or during the day for social interaction including news awareness. Also maybe organised trips' and 'Those with higher needs and those with less demands

Evidence:

should be assessed and maybe guided by staff to differing groups for activities so as not to become frustrated and bored'.

Staff surveys included comments about what the service could do better, such as 'Have more activities for residents' and 'To arrange activities to suit all the clients'.

Some of the care plans we looked at did not contain any information about social activity, this shortfall had been identified in the care plan audit undertaken immediately prior to this visit.

We saw an activity folder in lounge/diner on the ground floor residential unit. This included a copy of the Partridge Care Centre newsletter celebrating residents' birthdays and providing a profile of individual staff members so that residents and their relatives may get to know the people providing the care. There was a record of what activities each person had done. An example being where people had been taken out for walks, accompanied, some in wheelchairs, then making a collage out of leaves collected whilst out for the walk. There were records of a discussion that reminisced about items of kitchen equipment in times gone by. We saw some ladies having their nails done and enjoying a 1:1 chat with staff whilst this happened. When one person became agitated, we saw a member of staff calming this person by diverting them with a game of dominoes.

A relative told us that there was very little to occupy people living in the home, they said "I once saw a carer doing a quiz with residents". Another relative told us "X now has a daily newspaper which they enjoy". A resident told us " I like my bit of gardening".

Care plans included a document titled 'getting to know you' completed by families to provide information about peoples' previous lives, hobbies, occupation and interests. The social activity element of the care plans we looked at had not been developed to embrace this information therefore peoples' activities were not arranged specifically around their individual needs and preferences.

We observed staff earnestly trying to engage people in activity in the home. There needs to be more awareness about the needs of people living with dementia and to introduce meaningful 'activity' as an integral part of life. Activities for people living with dementia cannot be left to activity groups and sessions run by designated staff. To support and enhance peoples' self esteem and improve their quality of life 'activity' should happen at appropriate moments throughout peoples' waking life at the home. We saw there was a pile of magazines on a small side table for residents to browse

Evidence:

through, we were later told that a family member had brought these into the home. The environment was very neat and tidy however this meant there was little for people to wander about to do, to investigate or to just 'potter' with.

Visiting was open and people said that they could welcome visitors at any time. A visitor told us that they were always made welcome.

Some people invited us to look at their personal rooms. This showed us that they were able to bring their individual personal possessions into the home when they moved in.

Staff told us that some people were occasionally supported to make a cup of tea but there was concern because there was a constant hot water boiler in the kitchenette attached to the lounge and people may scald themselves. The deputy manager and residential unit manager thought they remembered risk assessments had been developed around this activity but could not confirm this. There was a sign on the kitchenette saying 'staff only'. Staff told us this aimed for visitors rather than the people living at the home as it could be difficult at peak times to make the residents' meals and drinks if the facility was full of visitors. There was a Bistro area in the entrance hall of the home specifically for visitors to obtain drinks and snacks.

We observed one person enjoying having a postcard read to them by a staff member.

The manager's AQAA stated: 'Meals are cooked on the premises, and reflect the needs of the Residents in terms of choice, and special dietary requirements. Residents can choose where they have their meal (in the communal dining area or in their room), and all Residents who need support during mealtimes receive the level of help they require'.

The home had experienced difficulties with staffing levels in the kitchen. On the first day of this inspection there was one person on duty in the kitchen. The deputy manager told us the service was in the process of recruiting kitchen staff. Staff told us food stocks were of good quality and that the kitchen equipment was in good working order. Today's meals were soup, sandwiches or cheese and potato pie for lunch with a choice of beef and tomato stew or fishcakes for evening meal. The cook told us there were fresh vegetables on the menu daily. We took copies of 2 weeks menus to study further. These showed that people were offered choices from a varied menu. It was noted that the choice of main meal on Fridays was limited to battered cod or poached cod on one week and breaded plaice or poached cod the next. These were not effective choices for people not fond of fish. During feedback following this inspection visit the registered manager told us that if there was nothing on the menu that people

Evidence:

liked, an alternative would be provided for them. The registered manager also reported that a quarterly survey would be undertaken in line with the changing seasons to determine what food people living in the home at that time wished to eat.

We observed the activities person consulting with residents about their meal choices for the following day. People living with dementia would not necessarily be able to remember these choices from one day to the next. Aids such as picture menu cards showing the day's meal choices would help to stimulate peoples' interest in food, as it is helpful to see what food looks like, and help them make meaningful choices about what they want to eat.

Survey responses about the food provision at the home were limited and varied. One person said they always like the food at the home, one said usually and one said sometimes. Comments about the food included: 'Food is very nice and it is always hot', 'Good food', 'Regular mealtimes with larger portions would be better(Vegetables require more cooking time)' and 'Meal times often different, sometimes X has to wait'.

Recorded minutes of a residents' meeting of 8th September included 'People have also requested that it would be nice to have a cup of tea at 7am as waiting until breakfast is too long'.

Complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them know how to complain. Any concern is looked into and action taken to put things right. The care home safeguards people from abuse and neglect and takes action to follow up any allegations.
People's legal rights are protected, including being able to vote in elections.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People can confident that their complaints and concerns will be listened to however records may not always confirm this.

Evidence:

The manager's AQAA stated: 'We have promoted a culture of 'open and honest' communication. We have taken all concerns seriously, and dealt with them before they become complaints. We endeavor to take criticism constructively, and use this to improve our service'.

The policy and procedure for dealing with complaints was included in the Statement of Purpose. The complaints policy and procedure stated that: 'Minor problems should be brought to the attention of the senior person on duty, who will do their utmost to resolve the situation immediately. The matter will automatically be reported in writing to the management'.

Records indicated there had been no complaints received since the home opened. The deputy manager reported there was a planned relatives' meeting for the end of the month to give relatives the opportunity to voice suggestions or concerns.

Minutes of a residents' meeting of 8th September included reference to rudeness of a member of staff on night duty. The deputy manager was able to describe what had been done to address this issue however this had not been recorded as a complaint

Evidence:

and it was therefore not possible to assess if this person's concerns had been dealt with appropriately.

A resident told us: "No complaints what so ever" A relative told us "Pretty good, nothing to complain about".

Staff training records showed that 17 of the 39 staff had attended training in safeguarding vulnerable adults. We were given a training plan that showed that the remaining staff members were booked to attend this training over the next four weeks. We noted that the management team were not included in these training records. Staff we spoke with at this visit demonstrated an understanding of adult protection procedures and what constituted abusive practice.

Documentary evidence was provided to show that people had been safely recruited to care for the people living at Partridge Road Care Centre.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, pleasant and hygienic.
People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People live in clean, safe and fresh surroundings however the home does not provide an enabling environment for people living with dementia.

Evidence:

The manager's AQAA stated: 'A newly built Home which has large individual bedrooms, all en suite, and wide/bright corridors. Facilities within the Home are 'over and above' general specification. Home well maintained in terms of decoration and health and safety. Enclosed garden area with seating. Specialist equipment for safety and comfort, including various hoists, and baths. Keys are available to all Residents rooms (where required)'.

In surveys 10 of the 12 people responding said the home was always clean and tidy.

We took a physical tour of the two units that were operating at the time of this visit. The environment was clean and tidy with no malodours present. The ground floor had two lounge/diners, the staff told us that the residents preferred to all share the same lounge/dining room facility. The second facility was used for arts, crafts and games at this time.

The decoration throughout the units was clean and fresh. However, the walls were all pale colours, with no distinguishable features, such as pictorial signs for people to

Evidence:

orientate themselves, or colour contrast on walls and doors help make the building understandable to those with impaired memory and high levels of anxiety. Good signage and use of colour would help people identify key areas, such as bathrooms and toilets.

Currently there were small name labels and room numbers on peoples' bedroom doors to identify them. The deputy manager reported the intention to introduce a laminated A4 sheet of paper with a photograph of the person living in the room, the name of their key worker and some art work relating to the person's hobbies and pastimes (eg football). The registered manager told us that consideration was being given to making the home more 'user friendly' for people living with dementia, for example, it had been discussed about painting peoples' bedroom doors the same colour as their front door had been at home to help them identify their own space.

The chairs in the lounge were all arranged around the outside of the room giving an institutional feel. It was positive to note that the chairs in the lounges were of different styles to provide options for peoples' comfort and to counteract some of the institutional appearance.

The dining area contained small tables to seat 4 people each. Each living unit had it's own 'servery'. Hot trolleys were delivered from the central kitchen and then meals were dished up for individual residents from there.

Some residents invited us to look at their personal rooms. It was clear to see that people were encouraged to bring personal items into the home to make their rooms comforting and familiar.

Some of the ground floor bedrooms had their own door to the outside. We saw examples of outside seating, bird feeders and flower beds.

There was a hairdressing salon fitted with two 'lay back' sinks so that residents had the opportunity to have their hair done. Staff told us a hairdresser visited the home 3 times per week.

The view from the living unit on the nursing floor looked out over playing fields. A resident told us how much they enjoyed watching people walking their dogs, watching youngsters playing football and seeing the seasons changing by the colours in the trees.

Staff training records showed us that 19 of the 39 staff members had attended

Evidence:

training in the control of infection. The in house training plan showed us that the remainder of the staff team were scheduled to attend this training over the four weeks following this inspection visit.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable to care for them. Their needs are met and they are cared for by staff who get the relevant training and support from their managers.
There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People receive care and support from caring, safely recruited staff. The staff team have not received the basic core training necessary to keep people safe.

Evidence:

The manager's AQAA stated: 'Flexible rota and staff deployment to reflect the needs of the Residents. Robust recruitment policy, in-line with current legislation. Staff induction programme, based on the Skills for Care levels. Supervision sessions for all staff. Training plan to include all mandatory training, or training specific to the needs of the Residents; which can be adapted as required'.

Survey responses told us that 6 residents felt that staff always available when needed, 4 said there were usually enough staff and one said sometimes. 6 people told us staff always listen to them and act on what they say and 4 said usually. 3 relatives told us they felt that staff had the right skills and experience to meet peoples' needs and 2 felt this was usually the case.

Comments in these surveys from relatives included: 'Bright humorous attitude from most of the staff', 'Kind staff', 'Staff are all very nice', 'They could tell us the names of the staff', 'There could be more staff in the evening', 'Feel the centre is well understaffed in several areas now it's open and running', and 'I feel that the centre now needs more structure and staff as more residents have now come into care'.

Evidence:

Visitors to the home told us: "Caring side of things is particularly good, all staff, including domestic staff are all very kind, caring and friendly" and "The girls are lovely and caring" A resident told us: "Staff are very good". A healthcare professional told us: "Whatever I ask of them they do" and "Always appear to have enough staff on duty".

We noted that not all staff were wearing name badges. The deputy manager told us that official name badges were not yet ready, this had already been identified as an issue at the home. They had made up some temporary badges so that visitors to the home would know who they were talking to.

We looked at staff rotas to determine how many staff were on duty in the individual units to meet the needs of the people living there. On the nursing floor where 12 people were accommodated at this time, there was a qualified nurse and 3 care staff on duty in the mornings with a qualified nurse and 2 care staff in the afternoon. On the residential unit where 19 people were accommodated at the time of this inspection visit there were 3 care staff on duty in the morning and 2 most afternoons, sometimes 3. At night time there was 1 qualified nurse and 1 care staff member on duty on each unit.

We looked at recruitment documentation for 3 staff members to determine if people were being cared for by staff suitable to do so. The deputy manager told us that recruitment documents were held centrally at Head Office but that it was planned to have a copy of all staff documentation to be held at the home for inspection purposes. On the first day of this visit there were no complete records held for the three staff members sampled. However, the information necessary to show that people had been safely recruited was provided from Head Office within 24 hours. All necessary documentation was provided with the exception of photographs for 2 staff members.

Records showed that the staff training programme was still developing as new staff were recruited to meet the ever growing number of people living at the home. Records showed that training was provided in areas such as infection control, safeguarding vulnerable adults, dementia awareness, healthy eating, moving and handling, basic food hygiene and health and safety. We noted there were significant shortfalls in these basic core training areas. Examples include of the 39 staff working at the home at this time 9 had attended moving and handling training, 7 had attended basic food hygiene, 3 had attended health and safety, and 17 had attended safeguarding of vulnerable adults. Whilst it is acknowledged that securing staff training for a growing staff team is a challenge it must also be recognised that this is a very new team and it needs a

Evidence:

solid foundation of skills in these key areas in order to maintain the health, safety and welfare of the people living at the home.

The registered manager told us subsequent to this inspection visit that: 'For staff we are recruiting now we'll set up the basic core trainng over 3 days before they start to work at the home. Current staff with identified training needs would feed into these sessions'.

Records showed that 7 care staff of the 17 employed to work at the home had achieved a minimum of NVQ level 2 in care, 2 of these had also achieved NVQ level 3. Funding had been secured for 4 further people to undertaken NVQ 2 in care and one in housekeeping. At the time of this visit 2 people were undertaking NVQ 2 in business admin, 2 in team leading and 1 in housekeeping.

Management and administration

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is led and managed appropriately. People control their own money and choose how they spend it. If they or someone close to them cannot manage their money, it is managed by the care home in their best interests. The environment is safe for people and staff because appropriate health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately with an open approach that makes them feel valued and respected. The people staying at the home are safeguarded because it follows clear financial and accounting procedures, keeps records appropriately and ensures their staff understand the way things should be done. They get the right care because the staff are supervised and supported by their managers.

This is what people staying in this care home experience:

Judgement:

People using this service experience **adequate** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The health, safety and welfare of the people living at the home is not always promoted and protected.

Evidence:

The registered manager has held registration for two other care homes within the Rushcliffe organisation. She is a Registered Nurse, holds a level 5 NVQ in strategic management and is qualified as an assessor and internal verifier for City and Guilds.

The registered manager is not always in daily 'hands on' management of the service, she told us she attended the home a great deal at varying times including evenings and weekends. There are individual managers responsible for the nursing and residential units who report directly to the registered manager.

The manager's AQAA told us: 'The Home Management team displays a sound knowledge of person centred care, and this, alongside continuous quality improvement, is part of the culture of the Home. The Home Manager has a good

Evidence:

knowledge of the Company's policies and procedures, which are in line with current legislation. The Home Management team has good interpersonal, and leadership skills. The Home Manager promotes a culture of excellence through mentorship and training for all staff. The Home Management team is supported by a Senior Management Team, who collectively have relevant qualifications and experience. There is an emphasis within the Home on prevention with regards to all health and safety issues. The Home Management team has relevant qualifications for their roles.

A relative told us they had never met the registered manager despite the fact they visit their relative often. The registered manager told us of an instance where she had made herself available to visit some relatives in their own home beacuse they were anxious and were not able to visit the home.

The service had only been operating for 131 days at the time of this visit therefore we are mindful they may not have commenced their annual quality assurance system. The deputy manager told us that Head Office would be distributing surveys to all people involved with the home and a report of the findings would be given to the service to develop an action plan to meet any identified shortfalls and a copy would be submitted to the commission.

The home's administrator maintained pocket monies for nine people living at the home at this time. Three people shared the role of administrator, the system for documenting transactions was not clear and robust, this means that there is room for error. Monies were held for people to pay for hairdressing service, chiropody, newspapers and toiletries. Staff told us that sometimes relatives left monies for residents when they visited at weekends. There was no system for providing receipts for this or recording as money came into the home for residents. There was no system in place at this time for the management to audit funds held on behalf of residents.

The deputy manager supervised nursing staff, chef and heads of department. The residential manager supervised care staff on the residential unit. There was documentary evidence of some staff supervision however there was no formal programme of supervision to ensure that all staff were monitored and supported regularly. Bearing in mind that the staff team is brand new there would be an expectation that there would be a structured and dedicated time set aside for the member of staff to receive support and supervision from their supervisor. The deputy manager told us that they had 'only just got the correct paperwork from Head Office'.

Health and Safety certificates seen relating to such things as Fire Alarm system, nurse call system, lift service, hot water checks, emergency lighting system and the gas

Evidence:

supply.

We saw evidence to confirm that fire drills took place. A example of an unplanned fire drill was where a new member of staff pushed a fire alarm button thinking it was the door release button.

The emergency fire bell sounded at 11:50 hrs. We were in the top floor lounge at the time. 2 staff members did not respond at all to the sound of the bell and a third person was unsure what the bell signified. The fire doors all shut immediately. As it happened this was a false alarm and had been a resident leaving the building via a fire exit. Later in the afternoon the fire alarm sounded again. Staff from one unit acted in accordance with the policies and procedures by one representative going to the fire panel whilst other staff remained with residents. One unit did not respond again to the emergency bell. In the instance of a real emergency this lack of response could have put people in danger.

We looked at the records of accidents and incidents occurring within the home. Some recording was not complete, for example one report indicated an incident in a resident's room on 5th October. The report indicated that the incident had been witnessed however there was no information to say what had happened, who had witnessed it and how it had happened. The report not signed or dated. One incident reported bruising to a person's left arm and skin break and several small ones on right wrist and arm. There was no witness or explanation for this and no regulation 37 notification had been sent to advise the commission of the event.

We saw records to show that the service undertook a 3 month analysis of reported incidents and accidents in order to identify patterns or trends. In the report of the July to September analysis it was noted that 'training needed for all staff in completing accident forms'.

A visitor told us that one resident would not sleep in their own bedroom but would only sleep on a chair in the day room. Consequently the person 'shoo's' people out of what they perceives to be their bedroom early in the evening. One incident referred to this person 'lying sleeping on a chair and fell out onto the floor'.

There were significant shortfalls in the current staff training necessary to promote and protect residents' health, safety and welfare. These areas included moving and handling, food hygiene, health and safety and safeguarding vulnerable adults. Please see the staffing section of this report for more specific detail.

Are there any outstanding requirements from the last inspection?				
	Yes	☐	No	☑

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	3	14	Pre admission assessment of peoples' needs should be comprehensive and contain detail of needs, choices and preferences about the care and support they require. People should receive confirmation that the care home can meet their assessed needs. This so people can be confident that the home acknowledges their individual care and support needs and are able to meet their needs.	23/11/2009
2	7	15	Ensure that detailed care plans are in place for all identified needs and that staff use the plans to direct the care they provide. This is so that residents' needs are met in a way that they would prefer.	30/11/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
3	9	13	Medication records need to be accurately maintained to reflect the time they were given and by whom. This is so people can be confident they are having the right medication at the right time.	30/11/2009
4	12	16	Activities need to be developed to support peoples' individual needs and preferences including those people living with dementia. This is so people can enjoy meaningful stimulation and occupation.	30/11/2009
5	16	22	Attention needs to be given to ensuring all complaints made are acknowledged as such and recorded and dealt with in accordance with the homes' policies and procedures. This is so that people can be confident that any concerns will be taken seriously.	30/11/2009
6	30	18	The staff training programme needs to be progressed so that all staff members receive the relevant basic core training. This is so people can be	30/11/2009

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
			confident they receive care from a staff team with the skills and knowledge to keep them safe from harm.	
7	38	18	The manager needs to ensure that the whole staff team receive the relevant training to ensure peoples' health safety and welfare This is so that people can be confident that people living at the home are cared for in a manner that promotes and protects their health, safety and well being	30/11/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No	Refer to Standard	Good Practice Recommendations
1	22	Consideration should be given to improving the environment for people living with dementia in line with current good practice guidelines, for example clear symbols, photographs and use of colour for recognition and orientation etc.
2	35	Consideration must be given to developing, and the management auditing, a secure system of recording monies kept on behalf of the people living at the home.

Helpline:

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We want people to be able to access this information. If you would like a summary in a different format or language please contact our helpline or go to our website.