Review of compliance

European Care (Derby) Limited The Park Nursing Home	
Region:	East Midlands
Location address:	40 St Marks Road Chaddeston Derby Derbyshire DE21 6AH
Type of service:	Rehabilitation services Care home service with nursing
Date of Publication:	March 2012
Overview of the service:	European Care (Derby) Limited is registered to provide accommodation, treatment of disease and disorder, and diagnostic and screening for up to 41 people who require nursing or personal care at The Park Nursing Home.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

The Park Nursing Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with people who used the service and listened to what they had to say about their involvement in the care and support they received. We spoke with two people who told us they regularly go out into the community, either on their own or supported by care workers. We saw that care workers were attentive to people's needs and feelings during our visit.

One person told us "This is the best place I have lived, and I've been in a few places." Another said "I like it here, the staff are very good. I am very happy."

People told us they were able to spend their day as they wished. One person told us they spend time sitting in the garden during the day, another person was involved in planting vegetables.

We asked people about the meals and people commented that the meals were good and they enjoyed them. We saw that people had been asked what choice they would like from the menu, and individual requests, such as 'no gravy' were also recorded.

People told us about activities. They told us that a trip to the seaside was being organised, and that care workers also took different people into the city centre each week. They also told us that they could also arrange to go out individually with care workers. We saw information about activities was on display around the building.

People told us there was a religious service held once a month. A number of people continue to attend services at their own church, and representatives of the Roman Catholic

church visit and provide communion.

What we found about the standards we reviewed and how well The Park Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were supported to make choices about their care and their privacy and dignity was respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People were provided with care and support that met their needs. Lack of organised care records and not providing care in accordance with care plans meant there was potential for omissions in ensuring people's welfare.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Not everyone who used the service was protected from abuse or risk of abuse as the Mental Capacity Act had not been used consistently to protect people who can not make decisions for themselves or lack the capacity to do so.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

People had their needs met by sufficient numbers of staff. The increased needs of people who used the service meant that the current staffing levels may not always be sufficient to meet people's needs to their satisfaction.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People had their needs met by appropriately trained and supervised care workers.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People were involved in the running of the service. Systems for monitoring the quality of service were in place.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect

the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with people who used the service and listened to what they had to say about their involvement in the care and support they received. One person who had recently started to use the service told us staff had allowed her to sleep in that morning. She was then assisted to get up later during the morning. We spoke with two people who told us they regularly go out into the community, either on their own or supported by care workers.

People told us they were able to spend their day as they wished. One person told us they spend time sitting in the garden during the day, another person was involved in planting vegetables.

We asked people about the meals and people commented that the meals were good and they enjoyed them. We saw that people had been asked what choice they would like from the menu, and individual requests, such as 'no gravy' were also recorded.

People told us about activities. They told us that a trip to the seaside was being organised, and that care workers also took different people into the city centre each week. They also told us that they could also arrange to go out individually with care workers. We saw information about activities was on display around the building.

We were told that activity co-ordinators were employed for 28 to 30 hours a week. We did not have the opportunity to speak with these staff during our visit. The registered manager told us these staff organise in house activities, such as bingo, hand massage and arts and crafts. They also organise weekly trips into the city centre, either for shopping, attend a bingo session, tea dances, and the theatre. They also organise trips out to places such as the zoo and Trentham Gardens.

People told us there was a religious service held once a month. The registered manager told us a number of people continue to attend services at their own church, and representatives of the Roman Catholic church visit and provide communion.

Other evidence
We looked at the care records for four people who used the service. We found some evidence to support the person and / or their family had been involved in the assessment and care planning process. Information about a person's preferences had been recorded, especially around night time routines. This information had been used to inform the plans of care.

Care records showed that a range of risk assessments were completed and used to inform staff when developing plans of care (see Outcome 4). Privacy and dignity issues were also recorded in care plans. This means that care workers were aware of what action they need to take to maintain an individual's privacy and dignity.

Our judgement
People were supported to make choices about their care and their privacy and dignity was respected.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with people who used the service and with relatives. One person told us "This is the best place I have lived, and I've been in a few places." Another said "I like it here, the staff are very good. I am very happy." A relative told us "The staff work very hard." They also told us they were made aware of any problems straight away and they had been involved in updating the care plan.

We saw that care workers were attentive to people's needs and feelings during our visit. We saw a care worker discretely support a person who was feeling sick at the dining table. The care worker supported this person to leave the table and return to their comfortable chair with the minimum of fuss to this person or other people around the table. We saw care workers crouch down to be at the same level when speaking with people who were sat in comfortable chairs.

Other evidence
We looked at the care records for four people who used the service. We asked care workers how they were made aware of people's care needs. Care workers told us they had seen the care records and were involved in recording the daily logs. Care workers told us they were given a hand over report at the beginning of each shift, so they were aware of any changes in a person's condition.

We looked at the care records for four people who used the service. The care records were not well organised. There was no consistency in the layout and paperwork in the files seen. It would be difficult for a new member of staff to find information about a

person's care needs or condition quickly in the care files.

A registered nurse told us they thought the care files could be simplified. The registered manager told us there had been numerous changes to the paperwork provided by the company and as a consequence, care files contained a variety of documentation.

The care records showed that people's needs had been assessed, and included planning for any identified risks. This meant people's care needs had been identified. Plans of care were in place and gave staff instruction on how person's needs were met. Risk assessments relating to moving and handling, nutrition and skin care had been completed.

We saw in one person's care records that they had limited verbal communication in English, as this was not their native language. The care plan indicated that a picture board should be used to assist with communication. We asked care staff how they communicated with this person, and if there was a picture board in use. They told us this person used simple gestures to communicate their basis care needs. They also told us that a picture board was not in use. This means this person is at risk of not being able to make themselves understood and their needs not being fully met.

Care records showed that care plans were being reviewed and updated regularly, although not on always on a monthly basis. Risk assessments had been reviewed and updated. Daily records were also kept and gave an insight into how the person had been on a day to day basis.

Our judgement
People were provided with care and support that met their needs. Lack of organised care records and not providing care in accordance with care plans meant there was potential for omissions in ensuring people's welfare.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People who used the service and relatives we spoke with did not express and concerns about the conduct of staff or the delivery of care. People told us they thought the staff were good, and they talked about going into the community with care workers and they felt supported when doing this.

Other evidence
We asked a registered nurse and care workers about safeguarding vulnerable adults and the Mental Capacity Act and deprivation of liberty (whether people are able to make decisions about their lives and whether restricting them in any way is in their best interest). A vulnerable adult is someone who is unable to protect themselves from significant harm or exploitation due to their health, age or disability.

They told us they had received training on safeguarding vulnerable adults. Care workers had a good knowledge of how to recognise abuse and were able to tell us what action they would take if they thought abuse had occurred. Care workers knowledge of the Mental Capacity Act and deprivation of liberty varied. However, the registered nurse and care workers knew there was a deprivation of liberty authorisation in place for one person who used the service. They were also able to tell us what the authorisation meant for the person concerned.

Care records showed that the Mental Capacity Act had not been used to ensure the safety of individual people when they were unable to make an informed decision for themselves about an aspect of their life. The Mental Capacity Act is designed to

protect people who can't make decisions for themselves or lack the mental capacity to do so on a permanent or temporary basis. The necessary assessments had not been completed for people who clearly lacked capacity to make decisions.

The registered manager had recognised this shortfall in the assessment of people's needs. She told us that all of the care records would be reviewed, taking into account each person's capacity to make decisions, and a mental capacity assessment would be completed as required.

Over recent months we have been notified by the service when situations involving people using the service had occurred, which affected people's health, safety and welfare. We have also shared this information with the local authority who are the lead agency for safeguarding vulnerable adults when required. A vulnerable adult is someone who is unable to protect themselves from significant harm or exploitation due to their health, age or disability. The local authority had investigated the most recent situation by carrying out a medication audit and made a number of recommendations relating to updating the medication policy. The incident had been resolved and the referral closed.

Our judgement
Not everyone who used the service was protected from abuse or risk of abuse as the Mental Capacity Act had not been used consistently to protect people who can not make decisions for themselves or lack the capacity to do so.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People we spoke with told us care workers supported them to go into the community, although these trips were usually organised in advance. We observed care workers were attentive to people's needs, and attended to people quickly when they requested assistance. However, relatives told us they thought staffing levels were low, and the care workers did not have enough time to sit and talk with people. One relative told us "I will tell you this, when there are one or two empty beds, they cut the staff hours, that's just not right."

Other evidence
The local authority received information from relatives during October and November 2011. The information they received suggested that staffing levels may not have been sufficient to meet the needs of people who used the service. This was because staff were slow to answer call bells, attend to toileting requests and people looked unkempt. The local authority worked with the families and the registered manager to satisfactorily resolve these issues.

Registered nurses and care workers were asked about staffing levels. They told us the staffing levels were based on occupancy and not the needs or dependency of people who used the service. They also told us the needs of people who used the service were increasing and the current staffing levels, although sufficient to meet people's care needs, did not provide time for staff to sit and talk with people on a one to one basis.

We observed that care workers were attentive to people's needs, and responded

quickly to requests for assistance. We did observe care workers spending time sitting and talking with people, but this only happened occasionally during time we sat and observed. We observed that sufficient care workers were available to serve and support / assistance people with their lunch time meal.

On the day of our visit, there were 39 people living at The Park. The rota showed that eight care workers were roistered on duty during the morning shift and seven care workers were roistered on duty during the afternoon/evening shift. Two registered nurses were roistered on duty from 8 am until 6 pm; one registered nurse roistered on duty until 9 pm, then one registered nurse and three care workers roistered on night duty. The registered manager was supernumerary at all times.

The registered manager told us additional care workers can be provided to meet the needs of specific individuals, for example, if they require one to one supervision.

Our judgement
People had their needs met by sufficient numbers of staff. The increased needs of people who used the service meant that the current staffing levels may not always be sufficient to meet people's needs to their satisfaction.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People who used the service and relatives we spoke with did not express any concerns about staff not having the skills or knowledge to meet their needs.

Other evidence
We asked a registered nurse and care workers about supervision. Supervisions are an opportunity for the manager and a staff member to meet on a one to one basis or observe the delivery of care. Supervisions can be used to talk about work practices, training needs, care and welfare of people using the service and other issues which impact on their role.

The registered nurse and care workers told us they received regular supervision. They told us they felt that supervision was productive, as they were able to discuss any issues. They told us that the person who supervises them also works alongside them when delivering care, in order to check they were following correct procedures. Care workers told us the management team were approachable and listened to any concerns they had and where ever possible, addressed these. We saw supervision records which supported that the supervisions were taking place.

We asked a registered nurse and care workers about the training they had received. They told us they had attended training courses and they received appropriate training to meet the needs of people who used the service. They told us they received mandatory training such as fire training, moving and handling training and infection control.

We saw the training plan for the staff team. This showed a comprehensive range of training was available to both registered nurses and care workers. The plan clearly showed the training each member of staff team had attended. The plan also identified which staff needed refresher training. The registered manager told us there is a dedicated training team, who provide in-house training.

Our judgement
People had their needs met by appropriately trained and supervised care workers.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not ask people or relatives about whether they were asked their views on the running of the service during this visit.

Other evidence
We saw regular audits were carried out by a manager from another home within the group. Areas that were audited included medication, care records, accident records, the environment, staff records and supervision. Any shortfalls were highlighted and an action plan developed by the registered manager. This action plan was then reviewed at the time of the next audit.

We asked a registered nurse and care workers about staff meetings. They told us staff meetings were held every two months, and an agenda for the meeting was provided before the meeting took place. They felt the meetings were productive and they were able to raise any issues and these would be discussed. They told us that management would raise issues on their behalf with the provider and would provide feedback following the discussions. Minutes of staffing meetings were not available at the time of our visit.

The registered manager told us 'residents meetings' were organised by the activity co-ordinators. She told us these meetings were poorly attended by relatives. The format of the next meeting was a 'Cheese and Wine Evening' with entertainment, to try and encourage more families to attend. This meeting was organised for the week after our visit. We looked at the minutes of the last meeting. The minutes demonstrated that

people were involved in making decisions about regular activities, trips out, redecoration and refurbishment of the building, as well as planning menus.

The registered manager told us a satisfaction survey had been carried out recently and the results were generally positive. The results had been developed into a report that will be shared with people and their families.

Our judgement
People were involved in the running of the service. Systems for monitoring the quality of service were in place.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Lack of organised care records and not providing care in accordance with care plans meant there was potential for omissions in ensuring people's welfare.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Lack of organised care records and not providing care in accordance with care plans meant there was potential for omissions in ensuring people's welfare.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Lack of organised care records and not providing care in accordance with care plans meant there was potential for omissions in ensuring people's welfare.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: The increased needs of people who used the service	

	meant that the current staffing levels may not always be sufficient to meet people's needs to their satisfaction.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: The increased needs of people who used the service meant that the current staffing levels may not always be sufficient to meet people's needs to their satisfaction.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: The increased needs of people who used the service meant that the current staffing levels may not always be sufficient to meet people's needs to their satisfaction.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Not everyone who used the service was protected from abuse or risk of abuse as the Mental Capacity Act had not been used consistently to protect people who can not make decisions for themselves or lack the capacity to do so.	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Not everyone who used the service was protected from abuse or risk of abuse as the Mental Capacity Act had not been used consistently to protect people who can not make decisions for themselves or lack the capacity to do so.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Not everyone who used the service was protected from abuse or risk of abuse as the Mental Capacity Act had not been used consistently to protect people who can not make decisions for themselves or lack the capacity to do so.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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