Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Preston Private

Midgery Lane, Fulwood, Preston, PR2 9SX

Tel: 01772796801

Date of Inspection: 13 June 2013

Date of Publication: June 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safety, availability and suitability of equipment	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Parkcare Homes Limited
Registered Managers	Ms. Siobhan Bailey Mrs. Gillian Bratt Mr. Paul Lewis
Overview of the service	Preston Private care home provides nursing and personal care only to 106 people. The home consists of four separate units. One unit provides personal care to people living with dementia, one personal care to older people and two units providing nursing care. The home is located in the Fullwood area of Preston. The home has three regulated activities. Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury and diagnostic and screening procedures.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 13 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with carers and / or family members, talked with staff and reviewed information sent to us by other authorities.

What people told us and what we found

We looked at outcomes 1, 2, 4, 11, 12, 16 and 17. At our last inspection we found non compliance with outcome 1. At this inspection we observed that improvements had been made and all outcome areas were assessed as compliant.

People told us what it was like to live at this home and described how they were treated by staff and their involvement in making choices about their care.

People also told us they could choose what and when they did things in the home. People told us they decided how they wanted to be supported with their care and this included the gender of their carer. We saw that there were no rules imposed on people.

People had their needs assessed and we saw that they were asked about their care and support and agreed to it. People told us they were treated with dignity, kindness and respect.

People's care and support plans detailed their care needs and these were kept under review. We found family members were happy with the care of their relations

People told us that they were consulted about the quality of the service they received and if they had concerns or complaints about their care they knew who to talk to.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People said they were involved in the decisions about their care and the care they received. It was evident when speaking to people that they had been involved in their care decisions if they wished to be.

Three of the four two people we spoke to understood the reference to a care plan and could tell us how they had been involved in the care plan being developed and reviewed.

We saw that staff spoke respectfully to people when talking to them. Staff were friendly and smiled at people and used quiet tones of voice to respond to requests for help. We saw that staff explained to people how they were going to help and support them. One person told us, "I have to use a hoist and they know I don't like it so we have a bit of banter to take my mind of it. I tell them (staff) 'you are like stuck records repeating yourself' and we have a laugh". We observed all groups of staff knocking on bedroom doors before entering them. We observed staff helping people to eat and drink and they were patient and took their time to offer them their food at a pace that suited them. One person said that the staff that supported them was polite and courteous and said, "Great staff, all know their job. They are lovely lasses and lads; they are polite and treat me right even when I lose my temper with them".

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We looked at how people using the service gave their consent to their care and treatment. To do this we looked at care and support plans and specific records of assessment of capacity. We looked at how care and support plans guided staff on how to support people where they were issues about capacity were identified. We saw that no people living at the home had any restrictions in place that had been agreed under the Deprivation of Liberty Safeguards (DoLS).

We saw good examples where staff had acted in the best interest of people to ensure they received the right care, treatment and support. For example a family had wanted their relative not to have life sustaining treatment when their health deteriorated. Staff arranged a best interest meeting with the family and other's involved in the person's care and when the person's health improved they were able to make the decision about their future treatment should their health deteriorate. This mean that staff protected the person's right to receive care and treatment.

We saw and example where a family member had requested a meeting with their relative's doctor to complete a Do Not Attempt Resuscitation (DNAR) form. We did not see that the home had sought evidence that the family member could make legal decisions about the person's health or welfare. The information about the person's capacity was also conflicting as their care and support plans referred to the person being able to make decisions. The DNAR form had been signed by the family member and the person's doctor but was not reviewed for two years. The assessment was also unclear as to if the person lacked capacity, that the test had been repeated to decide how and when they lacked it.

The provider might like to note that where people are thought to lack capacity by their family members or other professionals involved in their care, that the assessment guidance under the Mental Capacity Act 2005 is followed. Any decisions about treatment to sustain or preserve life are agreed by people that have the legal powers to do so.

We looked at policies and procedures in place to support people make informed decisions. We observed practice and talked with five people living in the home and one family member visiting. We discussed with people how they were consulted about decisions regarding their care and treatment. One person told us, "I have this lovely bedroom with all

my own family photographs. I like to get my bedroom cleaned daily and I tell… the cleaner to do it each day and she does a lovely job. She comes and asks me when she can do it and tell her the time". Another person said, "I accept all the things staff do for me and never begrudge anything. They know their jobs very well. I have to have help with a bath and have one every week. That's what I want and that's what I get. They put me to bed straight after my bath as that's what I want".

We found evidence in care and support plans records that people and or their relatives had been involved in them. Reviews of care showed people's needs were monitored and changes to care planned for. We saw people had consent forms to consent to having their photographs taken, medication administration, access of information, money management, use of bed rails and preference for gender of carer. However this did not routinely cover consent to being checked during the night.

We discussed training on understanding capacity with seven staff and the clinical manger. We were told by staff that they had training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguard (DoLS). They said this helped them to understand their role and raise awareness of acting in people's best interest where people were not always able to be involved in their care and support. Staff we spoke to were aware of people's rights to make their own decisions and of their obligation to work within the boundaries of the Mental Capacity Act (2005]. Staff gave good examples of supporting people to make decisions or acting in their best interest. Where family members instructed staff to provide care they were not sure was in keeping with their relative's best interest, we saw that they sought professional advice. Staff told us about the different ways they received training. This was by e learning, group or individual discussions or by live broadcast interactive teaching sessions through a training organisation. Training records showed the majority of staff had completed the training.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People we spoke to were complimentary about the staff. People told us that they were treated with kindness and respect and carers understood their needs. One person commented, "After my bath I get dressed and they put a big sheet around me so am never uncovered. The staff help me with my tablets since the stroke I take that many I rattle so told them to do it (administer tablets)".

People told us if they were not well staff would call their doctor. We saw that district nurse visited to provide care for people who required personal care only and not nursing care form the nurses on site. Care records also demonstrated that the home had good arrangements in place for responding to people's changing needs and worked closely with community and NHS professionals such as district nurses and general practitioner's. We saw in peoples care and support plans that doctors, chiropodist and health professionals visited the care home as part of the commissioning of services.

Not every person we spoke to could tell us what they thought about the service they received. We saw people were well dressed and attention had been given to their appearance. We observed how staff were attentive to peoples requests for assistance. Staff spoke to people respectfully and attended to personal care needs as required. People requiring support with their meal were given this with sensitivity. Comments from people about staff were "You won't find better staff anywhere else" And, "I call all the staff my Florence Nightingale's as they are so caring and attentive. If I need anything I just call them and they are there. I don't have to wait long and there a lot of people worse of than me here. Nothing is any trouble to them".

We spoke to care staff on duty. They told us they followed care plans regarding people's care and could contribute to them. One senior carer said, "I get good support from the manager and clinical manager as well as the nurses. They are all very good, and answer my questions about resident's needs. I haven't been a senior for long but the support has helped my confidence. We are re writing care plans and involving residents and families as much as possible. …. the clinical manager is showing us how to be more person centred and this helps us".

We looked at the care and support plans of five people and associated care documents. We saw that care and support plans were very detailed and contained more person centred information. Care and support plans covered people's needs around their known medical problems, mobility needs, dietary requirements, medication, daily care needs, and also social areas such as hobbies, activities and important relationships. We found people had an up to date plan of care that had been reviewed and daily records maintained. There was evidence in daily records staff followed care plans and responded to people's needs as required. The clinical manager told us that the home was going through a process of reviewing all the care and support plans so more person centred plans could be written in the future. They said that staff were having guidance and training so staff had the same level of understanding.

Risk assessments had been carried out. These were linked to peoples' welfare and safety. Staff were made aware of who may be at risk of falling, developing pressure ulcers, or may not eat enough. The management of these known risks was planned for with risk preventative measures in place.

We spoke to a family member about the care of their relative. They said they had access to their relative's care and support plans and were monitoring that staff were completing these. They said that they were happy with the care their relative received and said, "I have no complaints about my mother's care".

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

We saw that as part of the quality monitoring of the service provided that the providers had a system in place for monitoring and maintaining the health and safety of the building, safety systems, portable and fixed equipment used and provided. We saw that the home was providing a safe environment and the portable and fixed equipment and systems in the home was serviced and maintained.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at staff records in relation to recruitment to the service. We found records of completed application forms, references received and evidence that, Disclosure and Barring Service checks (DBS) were completed for applicants prior to them working in the service. There was evidence recruitment and selection took account and applied equal opportunity to all applicants. This meant people were selected fairly and were the most suitable applicant to meet the needs of people using the service.

New staff had completed induction training. This had involved completing an induction and training programme to national occupational guidelines and then working alongside more experience staff and completing a probationary period. During the probationary period observations were made of their performance. Staff employed were given a job description, terms and conditions of employment and access to the provider's policies and procedures located in the staff room and on the provider's intranet.

Staff we spoke to told us their recruitment was thorough and they were not confirmed in post until all the necessary processes were completed. Staff we spoke to said they felt valued by the management and were encouraged and supported to obtain qualifications.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We looked at the quality assurance system in place. We saw the home had been accredited with Investors in People in 2012. We spoke to the manager about a business plan. We were told the business plan for the home was being developed and would cover a period of five years. For example, agreeing a major refurbishment of the home which was waiting to be agreed.

We saw evidence that meetings were held for people using the service and relatives. The manager said the meetings were repeated in the evening and weekends so people living at the home and relatives had the opportunity to attend. We also saw minutes of the regular staff meetings held at the home and health and safety meeting. People living at the home told us that improvements had been made to the quality of the services offered as a result of the meetings held with them. One person told us, "Things have changed for the better, for example the food. We were having mince three times a week or sausage. Pudding was either a jam doughnut or ice cream, there was just no choice. There has been a huge improvement and other residents are saying the same thing and people are eating in the dining room again. We were not happy and … the manager had a meeting with us and we said what we thought. It's good we are listened to. There's a meeting next week to discuss the new menu". Another person told us, "I go to the meetings and say my piece. There are some …. (residents) here who have been here longer than me and say they know what's needed to improve. I tell them to ….. as I'm having my say. There's been huge improvements since … the manager arrived. The meals were something that everyone complained about as they were rubbish so much no one wanted to go to the dining room to eat. Mince three times a week, there's only so many ways you can do mince and we had them all regularly. We have a temporary chef and he's brilliant and the food is lovely. It's nice to know that someone takes an interest in the food you want and like. Everyone is now saying how nice the food is and there's improvements all around. You can say if you are not happy. …. the previous manager never did a thing. …. the new manager does listen and she visits here everyday and you can talk to her".

The manager had introduced a daily meeting of staff that were in charge of each unit. These took place at 14:00 each day and were attended by manager and clinical services

manager. Staff told us that these meetings were a useful way of communicating any concerns or issues that needed acting upon. One registered nurse said, "Yes the meetings are good for us. I can let the other team members know the priorities in this unit, for example if people are attending hospital for appointments and we need cover, or if I need advice about a patient's condition. You don't have to wait for a decision as decisions can be made there and then".

The manager undertook a range of audits at the home. These included; Medication, the environment, infection control, care plans, out of hour's manager visits and daily walk round audit by the manager. The home had a clinical governance audit conducted twice a year, based on the outcome areas of the essential standards and action plans were developed in accordance with the results.

Evidence was available that a monthly report was submitted by each unit manager to the home manager, which covered areas such as, weights of people using the service, monitoring for the development of pressure ulcers, infections, dependency levels and the use of bed rails. This information was used to develop key performance indicators for the home. These had been introduced to assess various areas of care needs. If concerns were raised for example, if a person had lost a significant amount of weight then this that was automatically identified so that the manager could track if there is an issue on one unit or within the home in general.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People we spoke to told us they were aware of the complaints procedure. We saw evidence that the complaints procedure was displayed in the home. People told us they were given support and reassurance to raise their concerns should they wish to exercise their right to make a complaint or comment and it would be acted upon and taken seriously. One person told us, "From moving in the nurse said to me if I had any worries to tell her or any of the staff. One staff member was a bit rough when they moved me, so I told the nurse. The nurse must have had a word because the carer apologised and has been polite and careful since". Another person said, "I see … the manager about the building and talk to her all the time. I won't say I know the complaints procedure but would tell her or the staff as I can say what I think and I will be listened to".
We saw that the provider had received verbal complaints from relatives and these were responded to appropriately.

Where the Care Quality Commission had received complaints concerning this service we had advised complainants to use the providers' complaints procedure as we do not handle individual complaints.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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