Rodenvine (Nottingham) Limited

Parker House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Parker House Nursing Home is a residential care home providing regulated activities personal and nursing care to up to 25 people. The service provides support to mainly older adults some of whom were living with dementia. At the time of our inspection there were 24 people using the service. Support is provided in one adapted building across two floors with lounges on the ground floor.

People's experience of using this service and what we found
Risks were not consistently managed or monitored. This placed people at an increased risk of avoidable harm. Risks relating to people's environment were inconsistently managed. Medicines were not always managed safely. People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices. People and their relatives told us they felt safe living at the service. Lessons were not always learnt following incidents. This meant there was an increased risk incidents could be repeated.

Staff were not always recruited safely, and we found the provider did not always ensure there were enough suitable staff to support people in a timely manner. The provider took immediate action to ensure safe staffing levels were in place. We have recommended the provider reviews their recruitment process to ensure all staff are safely recruited.

Internal quality assurance processes were not effective in monitoring the service. Health and safety audits were not always effective in monitoring safety and driving service improvement. People and their relatives were inconsistently involved in developing the service. The culture at the home was not always person centred. Relatives we spoke with told us they were informed when things went wrong. Staff worked in partnership with others.

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

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 28 October 2017).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We carried out a focused inspection to review the key questions safe and well led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this

inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led section of this full report. You can see what action we have asked the provider to take at the end of this full report.

During our inspection the provider took some action to address the concerns we found to mitigate risks. Risk reduction measures implemented during our inspection were found to be effective in managing some of the risks we identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Parker House Nursing Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to medicines, infection control, management of risk, the premises and quality monitoring of the service at this inspection. We have also recommended the provider reviews their recruitment process.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Parker House Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was carried out by 1 inspector, a specialist nurse advisor, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Parker House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Parker House Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service. We sought feedback from the local authority and integrated care board who commission care with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We visited the service on 28 and 29 November 2023. We also made phone calls to relatives on 30 November 2023. We spoke with 8 staff members including the registered manager, clinical lead, registered nurse, senior care staff, care staff, registered nurse, and the cook. We spoke with 1 visiting healthcare professional. We spoke with 3 people who used the service and 7 people's relatives. Not everyone living at the service was able to or wanted to speak with us, therefore we spent time observing interactions between staff and people. We reviewed a range of records. This included 9 peoples care records and multiple medicine records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, policies and training records were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks were not consistently managed or monitored. This placed people at an increased risk of avoidable harm.

● Risks associated with pressure area care were inconsistently managed. For example, care plans directed staff how often to reposition people to prevent pressure damage. Records we reviewed evidenced people were not always repositioned in line with their assessed need. This placed them at risk of developing skin damage.

● Management of risk to people's safety from falls and the use of bed rails were not always effectively managed. Although some risks had been assessed, care plans were not consistently clear, and some contained conflicting information. For example, a risk assessment relating to the use of bed rails was not accurate and contained incorrect information.

● Risks relating to people's environment were inconsistently managed. Window restrictors were not always fitted to comply with Health & Safety Executive (HSE) guidance. Restrictors fitted to people's bedroom windows were not tamperproof or robust, we found one window to have no restrictors fitted. This was a risk to people who could fall out of windows.

●Taps and exposed pipes had limescale present. This increased the risk of scalding, legionella and other water-borne pathogens. Whilst the provider did checks on water temperatures and legionella, the limescale present had not been addressed. Limescale build up offers a hospitable environment for legionella and other water-borne pathogens, this posed a risk to people.

● Further environmental risks had not been identified. For example, we found not all heavy furniture was fixed to the wall in people's bedrooms and a rusty toilet roll holder to have sharp edges. We also found a grab rail next to a toilet to be loose and hanging off the wall. Failure to manage risks associated with the environment placed people at risk of harm.

The provider failed to ensure the environment of the service was sufficiently maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider also failed to ensure risks relating to people's needs were always managed effectively this was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff undertook fire evacuation training and people had personal emergency evacuation plans in place which detailed vital information in case of an emergency occurring.

● The provider acted following our inspection to manage the risks associated with the environment, the provider removed the toilet roll holder and fixed the grab rail in the bathroom.

Preventing and controlling infection

● People were not always protected from the risk of infection as staff were not consistently following safe infection prevention and control practices.

● Areas of the home and furniture were unclean. Whilst the provider had completed regular infection control audits these were found to be ineffective as issues were not identified. We found some mattresses to be soiled. Failure to ensure mattresses were cleaned effectively or disposed of if no longer fit for purpose, placed people at risk of harm from the spread of infection.

● Areas of the home were not maintained which meant they could not be cleaned effectively. This increased the risk of infection.

● Some moving and handling equipment was found to be dirty. For example, moving and handling equipment in one person's bedroom was dirty and staff had not cleaned this after using it. Failure to ensure moving and handling equipment was cleaned placed people at risk of harm from the spread of infection.

The provider failed to ensure safe infection control practices which placed people at increased risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was using PPE effectively and safely. We observed staff to consistently wear gloves when supporting people. We also observed good hand hygiene practices which protected people from the spread of infections.

● People and their relatives told us they were happy with the cleanliness of the home. A relative we spoke with said, "My [relative's] room is lovely and clean, I always see the housekeeping staff around."

Using medicines safely

● Medicines were not always managed safely.

● Medicines were not always stored safely. Thickener prescribed for people at risk of choking was found in 2 people's bedrooms with their dispensing labels removed. None of those thickeners had opening dates and were stored in an unmonitored environment. Failure to ensure the safe storage of prescribed thickeners meant it was not clear if the thickener would be safe to consume. This placed people at risk of harm.

● There were missing records relating to medicines which were required 'as needed'. This meant staff did not have the correct in information in order to safely give these types of medicines. This placed people at risk of harm.

● Whilst staff received training in the management and administration of medicines. Specialist training relating to the administration of medicines used via a syringe driver for the management of pain was not completed. This placed people at risk of receiving their medicines unsafely. We fed this back to the provider who sought training for all staff during the inspection.

The provider failed to manage medicines safely. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who required time specific medicine for the management of Parkinson's and epilepsy received these on time according to the prescription. Staff told us they prioritised the administration of these types of medicines to ensure people did not suffer any unnecessary side effectives.

Visiting in care homes

● People were able to receive visitors without restrictions in line with best practice guidance.

Staffing and recruitment

● Staff were not always recruited safely, and we found the provider did not always ensure there were enough suitable staff to support people in a timely manner.

● Staff were inconsistently recruited. We found some of the staff files we reviewed had the correct information such as references and employment history, we found others did not. This meant the provider could not be assured staff were suitable to work with vulnerable people.

● We found there were enough suitably trained staff during the day to ensure people's needs were met, we found not enough staff were on duty overnight to ensure all people would be supported in a timely manner. We fed our concerns back to the registered manager who acted immediately and sought additional staff for night duty.

● People and their relatives told us they were supported by kind and caring staff who knew them well. A relative we spoke with told us, "The staff are kind and caring, the nursing staff are consistent, there are not many changes."

● We observed staff who were aware of people's individual needs to be kind in all of their interactions with people and their relatives.

We recommend the provider reviews their recruitment process to ensure all staff are recruited safely.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People and their relatives told us they felt safe living at the service. However, lessons were not always learnt following incidents. This meant there was an increased risk incidents could be repeated.

● Staff documented and reported concerns. However, incidents were not investigated thoroughly to ensure they were not repeated. We fed this back to the registered manager who told us they would review all incidents to ensure lessons were learnt.

● There had been no safeguarding concerns raised at the service for a prolonged period. The registered manager was confident this was correct but told us they would review documentation to ensure no concerns had been missed.

● People told us they felt the support staff gave them kept them safe. For example, a relative we spoke with told us, "My [relative] feels safe, staff give 100% all the time to make sure they are safe." A person we spoke with told us, "I am much safer than before I lived here, the staff do a good job in keeping me safe."

● Staff received training in safeguarding and felt confident to raise concerns about the people they cared for. Staff we spoke with knew what to report and who to report safeguarding concerns to.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Internal quality assurance processes were not effective in monitoring the service.
- Audits were completed and although some issues had been identified, action was not always taken to ensure the quality and safety of care improved. For example, medicine audits had been completed but had not identified any of the issues we found during our inspection.
- Health and safety audits were not always effective in monitoring safety and driving service improvement. Health and safety audits had been completed; however, issues were not always identified. For example, none of the issues relating to the environment we found during our inspection had been identified. This placed people at risk of harm.
- Lack of managerial oversight of care records meant these were not always accurate. For example, the issues we found with inconsistent and inaccurate care plans and risk assessments had not been identified. This placed people at risk of harm.

The provider did not effectively monitor the quality and safety of care to ensure improvements were made. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and their relatives were inconsistently involved in developing the service. We received mixed responses in relation to gaining feedback about the service. Whilst all relatives told us they were kept informed of changes by staff at the service and communication was good, not all of them had been asked their opinions on what improvements they would like to see. A relative we spoke with said, "We have had no meetings or filled in any surveys or questionnaires." However, another relative told us, "I have attended a couple of meetings now and we are always asked what they can do to improve."
- The equality and diversity policy in place detailed all protected characteristics, however not all staff had completed training in equality and diversity.
- Staff supervisions and meetings were held to encourage staff to raise issues. Staff told us they felt confident in raising concerns to the registered manager.
- People's individual religious and cultural beliefs were respected. For example, people were supported to celebrate religious holidays.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture at the home was not always person centred. Whilst staff supported people kindly, records demonstrated people did not always have accurate person-centred care plans in place. This meant staff did not always have the correct information to support people to achieve good outcomes.

● Care records were inconsistent; some care plans we reviewed indicated people and where appropriate their relatives had been involved in developing care plans whereas others did not.

● Staff told us the registered manager was approachable and supportive.

● People and their relatives felt confident and well supported by the registered manager and all staff. A relative we spoke with told us, "I know the manager and they are approachable. "All the staff are also approachable, kind and friendly."

Working in partnership with others

● Staff worked in partnership with others.

● Care plans we reviewed did not always evidence specialist advice had been sought in a timely manner. For example, we could find no evidence of people being referred to the falls team after multiple falls. However, the registered manager told us this was a documentation error and told us referrals had been made. This was supported by feedback obtained from a visiting professional.

● A visiting professional spoke highly of the registered nurses, "The nursing staff are experienced and efficient, they are always well prepared for discussions."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider understood their responsibility to be open and honest with people when things went wrong.

● Relatives we spoke with told us they were informed when things went wrong. A relative told us, "The home is very good with communicating, they always let me know if anything happens, it's very quickly resolved."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to manage and maintain the environment and equipment.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider failed to ensure the safe management of medicines. The provider also failed to ensure effective infection and prevention control processes were in place. The provider failed to ensure risks were monitored, assessed and mitigated.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider did not effectively monitor the quality and safety of care to ensure improvements were made.

The enforcement action we took:

We issued a warning notice.