PK Healthcare Limited

Parkdale Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Parkdale Care Home is a care home providing personal care for up to 30 older people in one adapted building. At the time of our inspection 27 people were living in the home. People have access to their own bedroom along with communal spaces including lounges and gardens.

People's experience of using this service and what we found
People were not always protected from potential harm as when incidents and accidents occurred these were not always investigated or reported. There were not always reviews of people's care records after these incidents to ensure action was taken to mitigate further risks. Some people did not always have guidance in place for staff to follow to keep them safe.

People were not supported by staff to have the maximum possible choice, control and independence, as people's capacity had not always been considered or best interests decisions made. There was a lack of understanding around this and staff provided us with inconsistent views of how people would be supported.

The systems in place were not always robust to ensure areas of improvements were identified. As incidents were not always investigated or reported we could not be assured duty of candour was fully understood. There was some evidence of lessons being learnt when things went wrong however further improvements were needed so this covered all areas. The provider had not always notified us of significant events that had happened within the home.

Medicines were managed in a safe way and people received these as prescribed. There were enough staff available to support people. People were happy with the staff that supported them and the care they received. The home was clean, and equipment was safe to use. People were supported to eat and drink and had access to health professionals when needed. Staff received an induction and training and people and relatives felt staff had the skills to support them.

Staff felt supported and involved with the service. They had the opportunity to raise concerns. Families and people felt the home was a nice place to live.

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

Rating at last inspection and update
The last rating for this service was requires improvement (Published 7 December 2021) and there were breaches of regulations.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

You can see what action we have asked the provider to take at the end of this full report.

Why we inspected
The inspection was prompted in part due to concerns received about the environment, staffing and the care people received. A decision was made for us to inspect and examine those risks.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to Regulation 11 (Need for consent), Regulation 12 (Safe care and treatment), Regulation 13 (Safeguarding service users from abuse and improper treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 effective?

Requires Improvement

The service was not always effective
Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-led findings below.

Parkdale Care 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector 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
Parkdale Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We also gathered

feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

During our inspection we spoke with seven people and three relatives. We also spoke with two directors, one of which is also the registered manager. The care manager and four care staff. We looked at the care records for 12 people. We checked that the care they received matched the information in their records. We looked at records relating to the management of the service, including audits carried out within the home.

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 requires improvement. The rating for this key question has remained the same. 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.

Systems and processes to safeguard people from the risk of abuse

- Staff told us they had received training and were able to demonstrate an understanding around safeguarding however not all incidents were investigated or reported to the safeguarding team.
- We were told about an allegation of potential financial abuse. The care manager was aware of this and this had not been raised with the safeguarding team. We asked the provider to raise this with the safeguarding team and received confirmation after the inspection this had been completed.
- We found a documented allegation of a sexualised incident. This has not been reported to the safeguarding team. We raised this with the safeguarding team after our inspection.
- We saw a person had a visible injury. We received mixed views from staff as to when or how this injury had occurred, and this was not documented. We sought assurances from the provider in relation to this injury after the inspection. We raised this with the safeguarding team after our inspection as the provider had not.
- It was documented people had other unexplained injuries such as bruises or skin tears. Although the care manager was able to offer some verbal assurances as to how these may have occurred, these incidents had not been investigated or reported to the safeguarding team. This meant we could not be assured people were protected from potential harm.

People had not always been protected from potential abuse. This placed people at risk of harm. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- At our last inspection we found risks to people were not fully assessed. At this inspection we found the same concerns. When incidents and accidents such as falls had occurred in the home there was no evidence reviews were taking place after the incident had occurred, although these were sometimes considered as part of the monthly review. When care plans and risk assessments were in place for people these had not always been updated to reflect these incidents.
- The information recorded in people's care plans and risk assessments was inconsistent. For example, one person's mobility care plan said they were at high risk of falls, but their risk assessment stated they were medium risk. This placed people at an increased risk of harm.
- When needed people did not always have care plans in place. For example, one person was on end of life care; however, there was no guidance for staff to follow and they gave inconsistent views on how they would support this person, during this time. For another person there had been incidents that related to their skin. There were no care plans or risk assessments in relation to this. We discussed this with the care manager who told us they were aware of this and they were working on implementing these.
- We observed a person was unwell. They told us they were unable to call for assistance as their call buzzer

was not working. They told us they had previously reported this. We checked the call buzzer, and this did not work. Furthermore, they told us they had tried to alert staff by standing on their sensor mat, however this had not alerted staff. When we checked this, it was not plugged in. We discussed this with the provider who took action to resolve it. We checked the other people who were in their rooms and found another call buzzer was unplugged. This meant people were not always able to call for assistance when needed.

Preventing and controlling infection

● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. There were numerous occasions where staff were incorrectly wearing face masks. The provider told us that staff only needed to wear face masks appropriately when delivering personal care, we did not see that a risk assessment was in place for this. The provider also told us this was referenced in their policy however on review of the policy this was not referred to.

● We were not assured that the provider's infection prevention and control policy was up to date. The provider sent us a copy of their policy after the inspection. On review this often referred to another care home. There was a link in the policy relating to government guidance, however this was not the most up to date guidance and referred to 2020.

Risks to people had not always been appropriately assed, reviewed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People felt safe living in the home and happy with the care they received. One person said, "Absolutely. As soon as I came into this place, I felt the love. They treat you like family. The registered manager is superb, you can have anything you want. Everybody, including staff, who comes into here knocks on my door. I would tell the registered manager if I didn't feel safe. I feel safe when they use the hoist to move me. They ask me if I'm ok and there is always two staff."

● The provider was continuing to update people's care files. For other people there were individual risk assessment and care plans in place.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care home

● Although there were set visiting times in the home for when families and friends could visit, they raised no concerns with us about this. The registered manager told us should someone ask to visit at a different time this would be accommodated.

Learning lessons when things go wrong

● There were some examples of when lessons had been learnt. For example, changes to the environment had been made to ensure it was safe for the people living in the home. The provider had also introduced an

action plan so that future concerns could be highlighted and actioned. However further improvements were needed to ensure action was taken in all areas for example, in relation to the incident and accidents that had occurred within the home.

Staff and recruitment

● People and relatives told us there were enough staff. One person said, "They never leave you long if you need anything". Another person told us, "I'm really impressed. They come straight away. If you buzz, they tell you if they can't attend to you straight away."

● We saw there were enough staff available for people and they did not have to wait for support. This included when people asked for assistance.

● Staff also confirmed there were enough of them and they could support people when needed. One staff member said, "Yes there are enough, it can be busy but that is okay, I have no concerns."

● The provider told us they used a dependency tool to work out staffing levels within the home, to ensure there were enough staff available for people.

● We saw staff had received the relevant pre employment checks before they could start working in the home.

Using medicines safely

● People told us they received their medicines as prescribed and raised no concerns. One person said, "I have two paracetamols in the morning. These help me to get up. I'm in less pain. I definitely get all my meds every day. They don't leave you with the tablets. They watch you take them."

● Medicines were administered to people in a safe way. The staff member stayed with the person to ensure they had taken it before leaving them.

● When people were prescribed 'as required' medicines there were protocols in place to ensure staff had the information to administer these medicines when people needed them.

● When people were prescribed creams there were separate charts that showed where people needed these to be administered.

● Staff administering medicines had completed training and a competency assessment to ensure they were safe to administer these.

At our last inspection the provider had failed to ensure premises and equipment were always safe. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● We saw the action the provider had told us they had taken since the last inspection had been completed. For example, hot water pipes had been removed/covered.

● Improvements had been made to the environment including new furniture and floor coverings.

● Environmental checks were completed for example, in relation to the fire risk assessment and lighting.

● A maintenance action plan had been introduced so any concerns with the premises or equipment in the future could be highlighted and actioned.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Since our last inspection we found not enough improvements had been made to ensure the service was fully working in accordance with the MCA.
- People did not have individual capacity assessments or best interests decisions in place when needed. There was a generic capacity assessment and best interests decisions in place for people, however this was not specific to the decisions being made.
- When applications had been made for DoLS, the provider had not always considered all restrictions that had been placed upon people. For example, when people were using bed rails, sensor mats, the locked doors within the home and restrictions on using the stairs. There were no care plans or risk assessments in place identifying how people were supported in the least restrictive way whilst these applications were considered. Staff we spoke with gave inconsistent accounts of how they would support people. This placed people at an increased risk of being unlawfully restricted.
- It was unclear who had a DoLS authorisation in place. The care manager told us they had started to complete a matrix, however this was not accurate as it did not reference one person. Another person's DoLS authorisation had expired and they were not aware of this.
- We found relatives continued to consent to care on behalf of people without the legal powers to do so. This meant the principles of the MCA were not always followed.
- Although staff told us they had received online training there was a lack of understanding around capacity and consent.

The principles of MCA were not understood or followed within the home. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed before they started using the service. This considered people's gender, culture and religion.
● People's physical and health needs were also assessed and considered.
● People and those important to them were aware care plans were in place and felt involved with their care.

Staff support: induction, training, skills and experience
● Staff told us they had received training and there was further training booked in the coming weeks, for example fire Marshall training. One staff member said, "Yes we have all the training, some of its online, it's all good. It helps us understand about supporting people." Improvements were needed to ensure staffs understanding of the training was ensured, as staff told us they had received MCA training, however they did not always know how to support people with this.
● People and relatives felt staff had the relevant training to support them.
● There was an induction process in place for new starters. This included training and the opportunity to shadow more experienced staff whilst getting to know the people they were supporting.

Supporting people to eat and drink enough to maintain a balanced diet
● People enjoyed the food available and the atmosphere was relaxed. There was a choice of meals available for people and people were asked before lunchtime what they would like that day. People had hot and cold drinks available on tables beside them and these were frequently replaced throughout the day.
● When needed people received support to eat and drink and staff took time with people and this was not rushed.
● People's dietary needs had been assessed. When people needed their fluid intake to be monitored, this was recorded and totalled up, where concerns had been noted, action had been taken.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support
● People had access to health professionals when needed, records showed people had been visited by the GP and district nurses. We spoke with a visiting health professional who raised no concerns with the home.
● People's oral health care was assessed to ensure people received the support they needed.

Adapting service, design, decoration to meet people's needs
Improvements had been made to the home since our last inspection. The home had been decorated in a variety of places. Several bedrooms had been refurbished and plans were in place for other areas within the home.
● The home was clean and odour free. One person said, "All of the home is clean. The cleaner hasn't been into my room yet today. I knocked over my coffee and it was cleaned up straight away. They clean my room every day."

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 requires improvement. The rating for this key question has remained the same. 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.

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

At our last inspection the providers systems had failed to identify concerns that we had found. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Although improvements had been made to the governance systems in the home, further improvements were needed to ensure they were robust in identifying all areas of improvement. For example, there was an analysis of skin tears and bruising, however this had not identified that no action had been taken following their occurrence.
● The provider showed us an audit that had been completed in relation to care plans. This was dated February 2022. Therefore, a more robust system was needed to ensure that areas of improvement with care plans were consistently monitored.
● The DoLS matrix that was being introduced had not identified all people on a DoLS or when DoLS had expired. The provider explained this was in the process of being completed.
● There were no systems in place to monitor if call bells and sensor mats were working, placing people at risk of harm.
● The systems and procedures in place were ineffective to ensure incidents and accidents were investigated or reported when needed.

Systems in place were not robust to ensure people were protected from harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We had not been notified of all significant event that had occurred within the home. This is a legal requirement from the provider. For example, a sexualised incident and where unexplained injuries had occurred. The provider had notified us of some events that had occurred.
● Other audits were in place which identified areas of improvements. For example, in relation to health and safety, medicines and infection control.
● Staff understood their roles and responsibilities and there were clear lines of delegation.

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

● We could not be assured duty of candour requirements were understood and met, as incidents were not always investigated or reported externally when needed.

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

● Feedback was sought from people who used the service, in the form of surveys or reviews. The feedback that we reviewed was positive.

● Staff felt that the home had improved and were supported within their roles. They told us they had the opportunity to attend supervisions and staff meetings. They felt any concerns they raised would be listened to and actioned.

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

● People liked the home and living there. One person said, "I like it here. I like all the staff but to different degrees. They look after me well. They work with me. The registered manager comes to talk to me a lot. They involve me."

● Staff worked with people and their relatives to ensure good outcomes were achieved.

Working in partnership with others

● The service worked closely with other agencies to ensure people received the care they needed.

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	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of MCA were not understood or followed within the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place were not always robust enough to identify all areas of improvement.

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 Risks to people had not always been appropriately assed, reviewed and mitigated.

The enforcement action we took:

Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from potential harm, as incidents were not being investigated or reported.

The enforcement action we took:

Issued a warning notice.