Advinia Care Homes Limited

Gorton Parks 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Gorton Parks is a nursing home registered to accommodate up to 148 people across five separate units. At the time of our inspection there were 140 people living at the service.

Three units specialise in either nursing or residential care (Sunnybrow, Abbey Hey and Melland). Part of Debdale is a nursing unit. The other half of Debdale and Delamere are 'intermediate' care beds which provide reablement services for people discharged from hospital. The care staff were employed by Advinia, with the NHS providing the nurses, physiotherapists and occupational therapists. All units come under the Gorton Parks regulation with the CQC.

Each unit has a lounge, dining area, a conservatory, and a kitchenette. All bedrooms are single with no ensuite facilities. Accessible toilets and bathrooms are located near to bedrooms and living rooms.

People's experience of using this service and what we found
Improvements had been made since our last inspection in the management of medicines. An electronic medicines system was now used which prompted which medicines were to be administered during each medicines round. Staff had received training in dementia and positive behaviour support. Staff were positive about the training and felt positive about the support they received.

However further improvements were required. Support plans for people who may become agitated were not detailed in the distraction techniques to be used and when the use of medicines may be appropriate. Records were not kept following incidents of distressed behaviour. Some daily records, for example the application of topical creams and when thickeners had been added to drinks were not fully completed. These issues had been identified in the provider audits but were still found during our inspection.

Risks were identified and plans in place to manage these known risks. Incidents were recorded on the providers computerised system and reviewed by the unit and registered managers to ensure appropriate actions had been completed. Staffing levels were sufficient to meet people's needs and staff continued to be safely recruited.

People were supported to maintain their health and wellbeing. 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.

There was mixed feedback from relatives about their involvement in their relative's care plans and communication with the home. Some relatives had difficulty getting their phone calls answered as staff were busy supporting people. The provider was looking into changing the phone system to address this issue.

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 22 July 2019). There were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We also met with the provider to monitor the progress against the action plan.

At this inspection not enough improvement had been made and the provider was still in breach of one regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last five consecutive inspections.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 10 and 1 June 2019. Three breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, good governance and staffing.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained as requires improvement This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gorton Parks 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 monitor the service.

We have identified breaches in relation to the quality assurance at the home in relation to the recording of incidents for people who may become agitated, the application of topical creams and the use of thickeners to manage the risk of choking.

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 and meet with the provider following this report being published 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 return to visit as per our re-inspection programme.

If we receive any concerning information we may inspect sooner.

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?

Good

The service was 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.

Gorton Parks 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 Care Act 2014.

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 two inspectors on the first day of the inspection and three inspectors on the second day. One inspector returned on the third day. Two Experts by Experience made telephone calls to relatives to gain their feedback. 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
Gorton Parks 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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
We spoke with seven people who used the service and 13 relatives about their experience of the care provided. We spoke with 23 members of staff including the registered manager, head of care manager, unit managers, nurses, senior care workers, care workers, housekeeper, activity coordinators and the chef. We observed staff interactions with people throughout the inspection.

We reviewed a range of records. This included 16 people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 the last inspection this key question was rated as requires improvement. At this inspection 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.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely; people in one unit did not always receive their medicines as prescribed, written guidance for medicines not routinely administered were not in place for the NHS units and medicines records were not always fully completed. This was a breach of regulation 12 (Safe Care and Treatment) 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 12, although some further improvements were required.

● People received their medicines as prescribed. Since our last inspection, an electronic medicines system had been introduced for the nursing and residential units. This showed the medicines were to be administered for each medicines round. The time of administration was automatically recorded, reducing the risk of medicines being given too close together. Guidance for as and when required medicines (PRN) should be administered was displayed when the PRN medicine was highlighted on the electronic medicines system.
● The NHS rehabilitation unit (Delamere and half of Debdale) did not use the electronic medicines system as the NHS managed their own medicines. Paper medicines administration records (MARs) showed people received their medicines as prescribed. An NHS pharmacist checked the MARs, stock levels and re-ordered the medicines.
● PRN guidance was in place on Delamere, but not for the NHS part of Debdale. This was also raised at the last inspection. We were told the PRN guidance was not needed as people were able to verbally communicate if they needed a PRN medicine. On Delamere, Advenia senior support workers administered medicines so PRN guidance was in place.
● Stock checks were completed once a month for each person when they were 'resident of the day.' However, we found some discrepancies on Sunnybrow. These were investigated following our inspection and found to be system and recording errors. The registered manager told us the electronic medicines system was due to be replaced by a different electronic system from June 2021 due to issues found with the current system, particularly around when PRN medicines stock was carried over from one month to the next.
● Topical cream charts provided directions for the frequency of application for the creams; although body maps were not used on Abbey Hey to highlight the areas of the body where the cream was to be applied. Staff signed the cream charts when they applied the cream; however; creams were not always applied as frequently as directed. There was no evidence that people's skin conditions had been adversely affected by

creams not being applied as directed.
● Thickeners, added to drinks to reduce the risk of choking, were not always recorded when used on Abbey Hey. Records were fully completed on the other four units. On Abbey Hey records had not been put in place for one person who had moved in three days before our inspection and records for another person had only been completed once in three days. Staff on Abbey Hey knew who required thickeners to be added to their drinks and the consistency of drinks each person needed. The recording of the use of thickeners had been an issue at our last inspection

We recommend robust systems are introduced to check that records for topical creams and thickeners are fully completed.

Assessing risk, safety monitoring and management
● The risks people may face had been identified, assessed and guidance provided for staff in how to manage these known risks. These were evaluated each month to ensure they were up to date. We found the risk assessments had not always been accurately scored as people's needs changed, although, for the assessments we viewed, this had not affected the overall risk rating for these risks.
● Some people living with dementia can become anxious and agitated. Guidance for staff to provide appropriate support at these times, including when the use of PRN medicines was appropriate, was not detailed; they did not describe the potential behaviour and referred to staff offering re-assurance and distraction. Staff we spoke with knew people and how to distract them if they became agitated.
● Incidents of agitation were noted in the daily notes and not recorded separately, as the behaviour was seen as 'usual' for the person. This meant information about people's behaviours; the triggers, frequency and how they were managed, was not readily available for any reviews of care plans or for the re-assessment of people's needs.

We recommend current best practice guidance is followed for the writing of detailed support plans for people who may become agitated and the recording of all incidents of agitation.

● Equipment was serviced, checked and maintained in line with regulations and manufacturer's instructions.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Incidents and accidents were entered into the providers computer programme called RADAR. Actions were automatically triggered depending on the type of incident, for example, 48 hour monitoring following a fall.
● All incidents logged into RADAR were reviewed by the registered and care home managers to ensure all investigations and actions had been taken to reduce the risk of a re-occurrence. Trends were analysed across the home and form month to month. The RADAR system could be accessed remotely by the regional director and Quality and Compliance managers.
● Staff had been reminded to ensure all incidents and accidents were added to the RADAR system and acted upon promptly.
● Members of staff completed regular safeguarding training and were aware of the procedures for reporting any concerns. Staff told us any concerns would be acted upon by the unit and registered managers.

Staffing and recruitment
● There were sufficient staff on duty to meet people's needs. Due to people's needs, many were cared for in bed and required two staff for their support. This meant staff were busy and supported people within their bedrooms.

● Staff told us they thought there were enough staff on duty, with each unit having a regular and stable staff team. A member of staff said, "Staffing is better now; everyone supports each other and things are working well."
● Staff continued to be safely recruited, with all employment checks completed prior to the member of staff starting work.

Preventing and controlling infection
● The home was visibly clean throughout. Housekeepers had a schedule for cleaning all communal areas and bedrooms.
● Staff were observed to be following the current government guidance for the use of PPE. Weekly COVID-19 testing was completed for all staff.
● Relatives were able to visit the home as per current guidance. They completed a COVID-19 test, wore PPE and went straight to their relative's room when visiting.

Good

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now improved to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Staff support: induction, training, skills and experience

At our last inspection staff had not received specific training to meet the assessed needs of people living in the specialist dementia units. This was a breach of regulation 18 (Staffing) 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 18.

● Care staff working in the dementia units had completed specific training for dementia. Face to face courses for positive behaviour support had also re-started in April 2021 following a gap due to the COVID-19 restrictions. This meant the staff working in these units had the training to meet the needs of people living with dementia and possible associated behaviours.
● Staff completed a range of mandatory training relevant to their role. This was managed through a training system which highlighted when training courses needed to be refreshed. Compliance in completing these courses was high and staff were positive about the training they received. New staff completed an induction book alongside their mandatory training.
● Staff said they felt well supported by their unit managers and were able to raise any concerns they had. However, regular supervision meetings were not being held and where they were completed, they had often been a group supervision as a staff team rather than individual meetings. This meant staff did not have the opportunity to discuss their own work and development with their supervisor. Some staff may not be confident raising issues in a group setting. The provider's policy states staff should have four supervision meetings per annum.

We recommend the home follows their own policy, national guidance and best practice for the planning and holding of regular staff supervision meetings.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional and dietary needs were being met. People said they enjoyed the food and there was a choice of meals available. Relatives told us, "I have seen [name] tuck in with a great appetite, so I think it must be good" and "[Name] is on a pureed diet, but he is eating more than he was at home."
● Information about modified diets and people's dietary and cultural needs was available in the kitchen. Staff completed a meal choice sheet each day and indicated dietary requirements on the sheet. Finger foods

were available to encourage people to eat if they did not want to sit down for a meal.
● People's weights were monitored and those considered to be at risk of losing weight were referred to the dietician or speech and language team. Where people were losing weight, snack bags were provided to encourage people to eat in-between meals. Food and fluid intake were monitored where required.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People were supported to maintain their health. Guidance was provided for staff to follow for any specific medical needs, for example supporting people with their diabetes. A weekly clinical review meeting for each unit gave oversight of clinical issues and checked all relevant referrals, for example to the falls team or district nurses, had been made.
● The registered manager produced a monthly key performance indicator (KPI) report. This monitored people's health or risks, for example weights, wounds and the use of bed rails or sensor mats.
● One local GP was allocated to each of the residential and nursing units, with all people living in that unit registered to this one GP. This enabled the staff and GP to build a consistent relationship. People in the NHS rehabilitation units kept their own home GP as they were only living at Gorton Parks for a short period of time.
● Tissue viability service referrals were made when required. However, on one occasion on Abbey Hey the referral had not been made in a timely way. This had been addressed by the registered manager and staff reminded to ensure any concerns with regard to skin integrity were promptly referred to the district nurse team.

Adapting service, design, decoration to meet people's needs
● Memory boxes had been re-installed next to people's bedrooms on Melland House since our last inspection. Abbey Hey also had memory boxes in place. They contained items that were meaningful to each person, which helped them identify their own rooms.
● Dementia signage was in place on the dementia units to assist people to orientate themselves within the home. Contrasting colours were used for doors to make them stand out from the surrounding wall. Coloured plates, plate guards and adapted cutlery were available to support people to eat independently.

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 Act 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 , and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service was working within the principles of the MCA. Care records contained capacity assessments for each specific decision.
● Where people had been assessed as lacking the capacity to make decisions DoLS applications had been

made. These were monitored by the registered manager so that re-applications could be made prior to the DoLS expiry date.

● Staff explained how they supported people to make day to day choices, for example what they wore and a choice of meals, by showing people the options available so they were able to choose.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Pre-admission assessments were completed prior to a person moving to Gorton Parks. The assessment provided by the hospital discharge team or social worker was used for the basis of the assessment and initial care plans. The resident and their family, where appropriate, were also asked about their support needs and preferences.

● Everyone moving to the home had to have had a negative COVID-19 test within 48 hours before moving in.

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 the last inspection this key question was rated as requires improvement. At this inspection 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

At our last inspection audits had not been robust audits with regard to medicines management, which was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made but further improvements were required and there was a continued breach of Regulation 17.

- The provider's computer-based quality assurance system had been embedded at the service since the last inspection. This scheduled audits weekly, monthly and six-monthly for a range of areas, for example medicines, support plans, clinical risk meetings, infection control and health and safety. These were mostly completed by the unit managers. The system prompted that any issues found during the audits had an action plan in place, with a named person identified to complete it.
- The regional and quality and compliance directors completed their own audit, scheduled to be bi-monthly. This checked a sample of support plans, medicines, KPI reports and staff support. At the time of our inspection (10 May 2021) these audits had only been completed in February 2021 and an action plan produced in March 2021.
- The homes audits showed a very high level of compliance. The regional and quality and compliance director's audits resulted in a lot more actions for each unit than the audits completed by the home themselves. Following the inspection, we were told minor issues found during the internal audits are corrected at the time and a comment to this effect made in the audit. Therefore, an action was not generated for as many issues. This meant there was a difference in the level of compliance recorded in the internal and external audits.
- Daily records, for example re-positioning, food and fluid, thickener and topical cream charts were meant to be signed off as fully completed at the end of each shift by the unit manager, nurse or senior care staff. This was not robust as we found cream and thickener charts not fully completed. In one case we found a person's cream chart had not been fully completed as per the prescribing instructions, which had also been highlighted as not being completed by the regional and quality and compliance director's audits in February 2021. This issue had not been picked up during the weekly medicines or monthly support plan audits.
- We found guidance for staff to support people if they became agitated and distressed was not detailed. This had also been an action set for one support plan by the regional and quality and compliance director's

audits in February 2021. This had been actioned; however, this had not been applied to the support plans for other people who could also become agitated. We had also made this observation in our last inspection report in July 2019. People's distressed behaviour was not routinely recorded to enable complete reviews of people's needs.

The continued issues with daily records, support plans for people who may become distressed and the lack of recording any distressed behaviours showed the quality assurance system had not addressed these issues and was a continued breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● The staff we spoke with were positive about working at Gorton Parks and felt well supported. They liked the weekly meetings held by the registered manager with one staff representative from each unit.

● The registered manager and head of care manager completed daily walk rounds of each unit, so they were updated with any changes on each unit directly.

● The service worked with a range of other professionals and community services. The local authority said the home and provider had worked well with them on an agreed action plan and had been focussed on improving the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● A new head of care manager had been appointed and a clinical support manager was due to join the home in the month after our inspection. The management of the nursing dementia unit had improved since our last inspection, with a stable manager in place to support the staff team. One member of staff on this unit said, "The staffing is now better and organised so we know who is doing what."

● Staff teams were allocated to work on one unit, with movement between the units limited. This had created more stable staff teams, who knew people's support needs.

● Daily meetings were held with the unit managers and head of departments, for example chef, housekeepers, to ensure any issues and changes were communicated across the service.

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

● We received mixed feedback from relatives about their communication with the service. Some said they had been involved in discussing their relatives support plans, whilst others had not. Relative meetings had been arranged via video, although attendance had been low. Letters had been sent to all relatives, although not all relatives had provided the home with an email address to be able to access these video meetings.

● Relatives also said they had difficulty in getting through to the units by telephone, as the phones were often not answered and they were unable to leave a message. The registered manager told us this was partly due to the phone system in place at Gorton Parks. They had requested for this to be upgraded. The provider was in the process of looking to renewing the phone network across the site and so the existing would not be upgraded in the short term.

● Relatives told us the staff would contact them if there were any changes in their relatives health or wellbeing.

● The provider arranged for surveys to be carried out with a sample of people living at the home and their relatives. The results from the 2020 surveys were generally positive. The registered manager had responded to any issues or comments from the surveys.

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 registered manager notified the CQC and safeguarding teams of any accidents and incidents as appropriate.

● A complaints policy was in place. Any formal complaints were investigated and responded to. Relatives we spoke with said if they had raised concerns verbally they had been addressed, with one telling us, "I haven't made any complaints except informally and these have always been sorted out."

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 17 HSCA RA Regulations 2014 Good governance The continued issues with daily records not being fully completed, the lack of detail in the support plans for people who may become distressed and the lack of recording any distressed behaviours showed the quality assurance system had not addressed these issues and was a continued breach of Regulation 17.