Canaryford Limited

Parklands 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

About the service
Parklands Nursing Home is a residential care home providing personal and nursing care for up to 54 people aged 65 and over. At the time of the inspection there were 50 people living at Parklands Nursing Home, some people may also be living with dementia.

People's experience of using this service and what we found
Effective arrangements were not in place to mitigate all risks for people using the service or staff employed. Not all appropriate measures were in place or being followed by staff to prevent and control the spread of infections and improvements were required to some aspects of medicines management.

Quality assurance and governance arrangements at the service were not as reliable or effective in identifying shortfalls in the service. Formal safeguarding procedures were not always followed to safeguard people using the service. Lessons were not consistently learned to improve the service.

The deployment of staff was suitable to meet people's care and support needs and staff recruitment procedures were safe. Proper arrangements were in place to ensure people received their medication as they should. People told us they were safe and liked living at Parklands Nursing Home. Relatives were complimentary about the quality of the service provided. Staff told us they felt supported and valued by the registered manager.

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 2 January 2020).

Why we inspected
The inspection was prompted in part due to concerns received about the management of the service, closed cultures and some aspects of medicines management. A decision was made for us to inspect and examine those risks.

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 coronavirus and other infection outbreaks effectively.

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

Follow up
We will request an action plan for 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

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Parklands 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 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 team consisted of two inspectors and a Specialist Advisor. The Specialist Advisor was a nurse consultant in practice improvement and dementia care.

Service and service type
Parklands Nursing 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
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 looked at all of the information we hold about the service. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with seven members of staff including the registered manager, qualified nurses, care staff, facilitator for social activities and hairdresser. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included people's care records, medicine administration records and a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the registered manager to validate evidence found and requested information relating to their quality assurance procedures. We looked at information relating to the service's quality assurance arrangements, including staff training data. We telephoned staff on the 18 and 19 January 2021 and spoke with five members of staff about their experience of working at the service. We also spoke with six people's relatives on 18 January 2021 to gain a view about their experience of Parklands Nursing Home and the care and support provided for their family member.

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 Good. At this inspection this key question has now deteriorated 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.

Preventing and controlling infection
• We were not assured the provider was always meeting social distancing rules in communal areas and this required improvement to keep people safe.
• We were not assured staff were adopting good hand hygiene practices. Although there was no longer an outbreak of COVID-19 at the service, where staff had direct contact [touching] with people using the service, staff were not washing or sanitising their hands between interactions. This placed people at increased risk of contracting COVID-19 or other infections. The registered manager told us 'pocket' hand sanitisers would be purchased and provided to all staff.
• We were not assured the provider was admitting people back from hospital safely to the service. People who were newly admitted from the community or from hospital were not admitted unless they had a negative COVID-19 test result. However, the registered manager confirmed people were not being isolated for a period of 14 days. Where this was not possible, or people refused to be isolated, this had not been risk assessed. This placed people at increased risk of contracting COVID-19 or other infections.
• Arrangements to assess current and emerging risks presented by the pandemic for people using the service and staff employed at the service, had not been considered or completed. This demonstrated a failure to assess people's vulnerability and susceptibility to the risk of getting COVID- 19. The registered manager told us they were unaware these were required to be completed.
• 'Donning and doffing' training [the practice of staff putting on and removing PPE in the correct order] for staff was completed in March and May 2020 but staff employed since May 2020 had not completed this. This was confirmed as accurate by staff spoken with. Comments included, "Donning and doffing, I have never heard of that" and, "I cannot remember doing this but one of the girls showed me what to do."

Using medicines safely
• The morning medication round did not complete until 11.00am. This placed people at risk of receiving their medication too close together or not receiving their medication in line with the prescriber's instructions. People told us medicines were regularly administered late.
• Although there were no unexplained gaps on the Medication Administration Record [MAR], this was not always accurately completed to demonstrate when people's medication was administered. For example, one person received their medication after 11.00am but the MAR recorded this as being administered at 8.30am.
• Thickening powders to aid a person's swallowing difficulties and to minimise the risk of aspiration were not stored correctly. These were stored in the communal lounge, dining room or within people's bedroom. This

was easily accessible to others and placed people at potential risk of harm and was not in line with the NHS 'Patient Safety Alert: Thickening Powders' dated 2015.
• Where oxygen is prescribed, this had not been recorded on the person's MAR.
• The temperatures for storing medicines were being monitored and recorded each day. However, action was not taken when the temperature exceeded the storage requirements that are specified according to the manufacturer's recommendations. The temperature had exceeded 26º every day since 1 January 2021 and there was no evidence to demonstrate the actions taken to reduce this in line with recommended guidelines.
• We were not able to ascertain if all staff who administered medication had up to date training or had had their competency assessed at regular intervals. Despite a request, medication competency assessments were not provided for five members of staff who administered medication.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Actions from the service's fire risk assessment remained outstanding since September 2018. This referred to a night fire evacuation plan, the appointment of fire marshals and training. The registered manager told us this would be actioned.
• Not all risks to people's safety and wellbeing were being recorded, monitored and managed effectively. Where people were prescribed long-term oxygen through a concentrator or nebuliser, risk assessments were not considered or completed to ensure people's safety and wellbeing.
• Observational tools that allow staff to record information about a specific behaviour or incident, were not completed well as they did not provide enough detail describing staff's interactions or outcomes.
• Where people had a catheter in place, not all related risks were identified and recorded. A catheter is a medical device used to empty the bladder and collect urine in a drainage bag. Risks associated with the catheter had not been considered or recorded, for example, bladder spasms, leakage around the catheter, blood or debris in the catheter tube, dehydration and the importance of monitoring people's fluid intake and output.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. 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.

• Following the inspection, the registered manager submitted an action plan. The action plan confirmed the service's fire risk assessment had been reviewed and updated and designated fire marshals had received appropriate training. Suitable arrangements had been made to ensure the manufacturer's recommendations relating to the storage of medicines was safe. Staff had received updated infection, prevention and control training and given individual bottles of hand sanitiser. Risk assessments relating to catheter care and the use of oxygen were now in place.

Systems and processes to safeguard people from the risk of abuse
• People told us they felt safe and relatives confirmed they had no concerns relating to the safety of their family member. Relatives told us, "[Relative] is definitely safe there [Parklands Nursing Home], I'm not worried about them" and, "Without any doubt, they are safe."
• Staff demonstrated a satisfactory understanding and awareness of the different types of abuse, how to respond appropriately where abuse was suspected and how to escalate concerns to the management team and external agencies.

Staffing and recruitment
• The deployment of staff was appropriate and there were enough staff to meet people's needs. Staff

responded to people in a timely way and call alarm facilities were answered promptly. Relatives comments included, "I think there must be enough staff as [relative] doesn't seem to go without" and, "From what I've seen when I was visiting, there seemed to be plenty of staff."
• Staff told us staffing levels were appropriate and there was enough of them to provide safe care to people living at Parklands Nursing Home. Staff confirmed they picked up additional shifts when required and staff were deployed from an external agency. One member of staff told us, "Staffing is usually fine."
• Staff had been recruited safely to ensure they were suitable to work with the people they supported.

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 Good. At this inspection this key question has now deteriorated 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.

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

• The quality assurance and governance arrangements in place were not reliable or effective in identifying risk and shortfalls within the service. The lack of oversight and monitoring at both provider and service level has led to a deterioration in the service.

• Audits and checks in place which were completed at regular intervals had failed to identify and address the concerns found as part of this inspection or to help drive improvement and lessons learned.

• Infection, prevention and control audits highlighted no areas of concern which required corrective action. The audits failed to identify the service was not fully compliant with government guidance. The medication audit for December 2020 identified discrepancies. However, an action plan was not completed to evidence actions taken or to evidence learning and service improvement.

• The provider and registered manager did not routinely act in accordance with the Mental Capacity Act [MCA] 2005. People's consent to COVID-19 testing had not been recorded and where people lacked the capacity to make this decision, MCA's and 'best interest' decisions had not been considered or completed. Following the inspection, the registered manager submitted an action plan. The action plan confirmed MCA assessments were now in place for people who lacked capacity to consent to COVID-19 testing.

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

• There was a lack of oversight to identify poor practice. For example, poor hand hygiene practices and aspects relating to medicines management.

• Statutory notifications which the service is required to send us were not raised with the Care Quality Commission. The registered manager identified significant concerns about inadequate hospital discharges and the impact this had on people using the service. However, although the registered manager told us they had spoken to a representative from the Clinical Commissioning Group [CCG], the registered manager had failed to follow the correct formal processes and procedures in referring these concerns to the Local Authority and Care Quality Commission.

We found no evidence that people had been harmed however, systems were either not place or robust

enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

• Staff told us they felt supported and valued by the registered manager and consistently described them as supportive and approachable. One member of staff told us, "[Name of registered manager] is very supportive and I know I can go to them at any time."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Arrangements were in place for gathering people's views of the service and these had been completed in November 2020. Comments received were positive and included, "The staff are so good, I feel that I'm being cared for well", "Very pleased with the service as it is" and, "I think the service here is faultless." Many positive interactions between staff and people using the service were observed during the inspection and staff were able to demonstrate a good knowledge of people's care and support needs.

Working in partnership with others
• Information showed the service worked closely with others, for example, the Local Authority and healthcare professionals and services to support care provision.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks for people must be assessed, recorded and mitigated to ensure their safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Improvements must be made to the service's governance arrangements to assess and monitor the quality of the service provided and to enable them to identify and assess risks to people's health and safety.