Care Quality Commission

Eldercare (Halifax) Limited

Parklands House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

Parklands House provides nursing care for up to 57 people whose primary care needs are mental disorder or dementia care. Qualified nurses, supported by care assistants, provide 24-hour nursing care. At the time of our inspection there were 35 people living at the home.

This was an unannounced inspection carried out over two days, 27 and 28 October 2014. During this inspection we looked to see if outstanding breaches in regulation and the warning notice, issued on the 15 September 2014 had been met. We also looked at other areas of the service to check the provider was meeting the regulations.

The home has no registered manager. 'A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.'

People's safety was being put at risk as the medicine management system did not demonstrate people received their medication as prescribed. We found there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Summary of findings

Suitable arrangements to effectively maintain hygiene standards within the home and minimise the risk of cross infections were poor. We found there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Where people's freedom was being restricted the management team had sought appropriate advice and support so that decisions could be made in people's 'best interests'. This helped to ensure people were protected. Accurate records about the individual support needs of people were not maintained. Care records did not reflect how people were being restricted, how risks were managed or reflect their changing health needs. We found there was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not always able to tell staff if they needed help. People were reliant on staff to identify any change in their health and well-being and seek appropriate help and advice. We saw where people had lost a significant amount of weight loss, this had not been acted upon. This could result in people's healthcare needs not being met. We found there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not receive care and support that was delivered in a dignified and timely manner. Visitors to the service told us they had witnessed people having to wait for assistance and they looked unkempt. They said people were left without staff supervision and had to seek out staff when people needed assistance. We saw staff did not always provide meaningful interactions with people. We found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were not always supported by sufficient numbers of staff to keep them safe. Due to the turnover in staff there had been a reliance on agency staff to support people. We found these staff were not aware of the individual needs of people. We found there was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Systems to monitor the quality of the service were not robust. Where audits had been completed and areas of improvement had been identified, the provider could not show us that appropriate action had been taken to improve the quality of service people received so that they were kept safe. This put people at risk of harm or injury. We found there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Effective management arrangements providing clear leadership and support for staff were not in place. New staff spoke positively about working at the home and the support they had received from colleagues. However existing staff had not received updated training and support in areas specific to the needs of people living at Parklands House. We found there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff recruitment processes had improved however not all checks about the suitability of staff had been completed prior to them commencing work. This puts people at risk of being cared for by staff that are unsuitable to work with vulnerable people. We found there was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us they liked living at the home and liked the staff. They told us they enjoyed the food and maintained relationships with family and friends. Improvements were needed so that people were effectively supported or encouraged to take part in activities specific to their needs and abilities.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Systems for the management of medicines were unsafe and did not protect people using the service or ensure they received their medication as prescribed.

People were not protected against unsafe or inappropriate care as identified risks had not been assessed and planned for. Further risks to people's safety with regards to cross infection and fire safety were not effectively managed so people were kept safe.

People did not receive the care and support they needed in a dignified and timely manner as sufficient number of staff were not always available.

People's relatives and visiting health and social care staff said they had witnessed people having to wait for assistance. We saw, at times, people were left without staff supervision and staff did not always provide meaningful interactions

Is the service effective?

Inadequate

The service was not effective. Where restrictions had been placed on people the provider had acted accordingly so that people's rights were considered and protected. However records needed expanding upon to show how decisions had been made in people's 'best interest' or how people had consented to areas of care and support

Clear and accurate information to guide staff and relevant training in areas such as Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had not been provided, promoting good practice for staff to follow.

Staff had not accessed support from relevant health care staff, such as dieticians, so that people's health and well-being was protected.

People were not protected from the risk of unsafe or inappropriate care as staff did not have the knowledge and skills needed to safely and effectively deliver the care people needed.

People were provided with adequate nutrition and hydration. Some people were not safely supported where they had specific dietary needs.

Is the service caring?

Inadequate

The service was not caring. People were not supported in a way which promoted their dignity, choice and independence.

People's personal information was not always kept confidential so that people's privacy was respected.

Is the service responsive?

Inadequate

The service was not responsive. Care records did not reflect people's needs, wishes and preferences about how they wished to be cared for.

People were not afforded stimulation or variety to their day. Opportunities to take part in a range of activities both in and away from the home were limited and did not consider their specific needs and abilities.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led. The provider had failed to appoint and register a manager, for some considerable time to ensure effective direction and leadership to the staff group was provided.

Effective systems were not in place to regularly monitor and review the quality of the service and facilities provided. The provider had failed to make improvements, where these had been identified, so people and their families could feel confident they would receive a good quality service.

Parklands House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 27 and 28 October 2014 and was unannounced. We looked to see if outstanding breaches in regulation identified at our inspections in June and August 2014 and the warning notice, issued on the 15 September 2014 had been met. We also looked at other areas of the service to check the provider was meeting the regulations.

The inspection team comprised of two adult social care inspectors. During the inspection we spent time speaking with three people who used the service, three relatives, a visiting health care professional and four staff. We also spoke with the deputy manager and operations manager.

During the inspection we observed how staff supported people in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at people's care records, staff recruitment and training records as well as information about the management and conduct of the service.

Prior to our inspection CQC had been involved in several multi-agency meetings where current issues and investigations were discussed with the local authority commissioning team, safeguarding team and the Clinical Commissioning Group (CCG).

Inadequate

Is the service safe?

Our findings

The service was not providing safe care. Prior to this inspection we had been made aware by the local authority safeguarding and commissioning teams, people's relatives and staff of their concerns about the care and welfare of people living at the home. Due to the seriousness of the concerns, safeguarding issues that involved 21 people have been considered by the local authority.

During this inspection we spoke with three staff to check their understanding of what constituted abuse and the procedure they would follow if they witnessed or suspected abuse had occurred. Staff were able to tell us what constituted abuse and said they would speak with the managers if they were concerned about anything. Policies and procedures were available to guide staff and we were told that training in safeguarding people was provided. On examination of training records we saw that only 15 of the 48 staff employed at the home had completed safeguarding adults training between 2010 and 2014. This potentially placed people at risk of harm as staff may not recognise and appropriately respond to poor practice.

Following this inspection we were informed by the local authority of further concerns raised by health and social care staff who had visited the home to speak with people and their relatives about the care and support received. We were told by the local authority that people did not always receive adequate or effective care in a timely manner, so people's dignity was not always maintained.

On the first day of our inspection we looked around the building. From our observations people were not kept safe when bedrails were in place. We asked the deputy manager if risk assessments had been undertaken in relation to the use of bed rails. We were told assessments were undertaken. However staff could not explain why they were absent from care records, nor could they locate them.

We asked how often safety checks were undertaken on the bed rails. We were told that safety checks were undertaken at least daily. The deputy manager could not show us any evidence that any bedrail safety checks had been undertaken. Failing to keep accurate records does not protect people who use the service from unsafe or inappropriate care associated with the use of bedrails.

We aware that a person had sustained an injury, which required dressing. We were told a dressing had been applied but was no longer needed. There was no record of a wound dressing being applied. Due to the lack of clear and accurate information there was no assurance the person had received the intervention required to treat the wounds.

We saw that a person was assessed as being at high risk of developing pressure ulcers and was being cared for on a pressure relieving mattress. We saw this was not the correct mattress for the person's bed. We saw this person needed two care staff to assist moving them. An inspection of their care records showed there was insufficient information to guide staff on the care required to help prevent pressure ulcers developing, such as bed rest, positional changes and diet. Nor had a moving and handling risk assessment been completed to guide staff on how the person was to be safely moved. Failing to identify, assess and manage the risks associated with moving placed the person at risk of harm.

Records for one person identified they had mental health needs and were closely monitored by staff and needed assistance to manage areas of identified risk. We had been made aware by the provider of incidents that had occurred involving this person. A Salford Tool for the Assessment of Risk (STAR) had been completed. This assessment was specific to people with mental health needs. This had been completed in July 2014 and reviewed each month. Where areas of risk had been identified, further assessments about how to manage such risks were required. We found these had not been done. We asked the deputy manager why the records were incomplete. We were told this was due to difficulties in printing the document.

There was a breach of Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Records did not provide accurate or sufficient information to guide staff in the delivery of care to ensure people's health, welfare and safety was not placed at risk.

We looked to see if the management of medications within the home was safe. We saw that six unlocked boxes of medications were left in the reception area and were accessible to people who used the service, staff and visitors. We were told by the nurse on duty that the medicines were awaiting return to the pharmacy. We also found a tablet in a medicine pot that had been left in one of the lounges where people were sitting. Leaving

medicines out in a communal area meant that anybody could take the tablets, either deliberately or accidentally. Failing to keep medicines secure placed the health and welfare of people at risk of harm.

We looked at the systems for the disposal, storage and administration of medicines. We also looked at the medication administration records (MARs) of seven people who used the service.

Medicines in current use were securely stored. We found following a check of medicine stocks and MARs that there was either more medication than there should have been or not enough medication in stock. It was not possible to tell therefore whether or not people's medicines had been given as prescribed.

One MAR showed the prescription was for a medicine that was to be given 'as required'. Information was not available to guide staff as to when they may need to administer this medicine. If information is not available to guide staff about as required' medicines need to be given, people could be at risk of not having their medicines when they actually need them.

Three of the MARs looked at showed that the people were prescribed topical creams. There was no evidence to show when creams had been applied as staff did not record when this was done.

We looked at the medication audit that had been undertaken three days prior to our inspection of 27 October 2014. The audit was not robust enough to identify the issues of concern that we found in relation to medication management. It is essential to have a robust system of audit in place in order to identify concerns and make the improvements necessary to ensure medicines are handled safely within the home.

There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Systems for the management of medicines were unsafe and did not protect people who used the service.

We looked at the records for four staff employed to work at the home during 2014. Relevant recruitment information, such as an application form, written references, identification and interview records were held on file. Criminal record checks had also been carried out with the Disclosure and Barring Scheme (DBS) prior to people commencing work. We did note that on one file there was no second reference and on a second file there was no information of the nurse's registration with the Nursing and Midwifery Council (NMC). This information is essential when making decisions about the suitability of applicants so people can be confident that the people who deliver their care have the correct qualifications skills and experience.

There was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected by robust recruitment practices which are required to ensure that staff are suitable to work with vulnerable people.

Prior to this inspection concerns had been raised with us by the local authority and a whistle blower about the staffing levels at the home, including the provision of night staff. Due to this our inspection on the 27 October 2014 commenced at 6.00am. There were two nurses and three care staff on duty to support the 35 people living at Parklands House. We were told that one of the care staff was providing one to one support for one person. We spoke with the nurse on the ground floor and asked if they felt there were enough staff to meet the needs of people. We were told that eight people required the support of two staff when being transferred by hoist to and from their bed. The nurse felt one nurse and one carer supporting the two ground floor units was sufficient during the night time. However they said that in the mornings, communal areas occupied by people were left unsupervised as staff were busy elsewhere within the home. This meant people had to wait for refreshments or assistance, if needed, as staff were not available.

One visitor we spoke with told us they had, until recently, been happy with the care their relative received. However they said over recent weeks there had not been enough staff on the unit. They said they had to seek staff out when people needed assistance. Care staff spoken with also told us they were short of staff at times. We were told there had been occasions when only three care staff were available to support the two ground floor units. We were also told by visitors, at times they had to wait to gain entry to the home or could not always find a member of staff if they needed to speak with someone.

Due to the high turnover in staff we were told that regular agency nurses and care staff were being utilised to cover the rota. During our inspection on the 27 and 28 October 2014 agency nurses and agency care staff were on duty

Is the service safe?

throughout the day and night. We were told by staff this was typical. However the deputy manager and operations manager said that recruitment was taking place and checks were being completed on those staff recently appointed.

We were told by the operations manager the provider used 'The Regulation and Quality Improvement Authority (RQIA) Tool 2009', in determining staffing levels within the home. We were told staffing levels comprised of two nurses, one on each floor, two carers on each of the ground floor units and two carers on the first floor. One carer was designated to provide 1:1 support for one person. What we were told and on examination of staff rotas we found these levels were not maintained. Without sufficient numbers of staff at all times, people are potentially at risk of not receiving the care and support they need to keep them safe.

There was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing levels were not always provided in sufficient numbers to adequately support the needs of people.

We looked at what plans were in place in the event of an emergency. A previous internal audit highlighted the lack of response made by staff during a fire drill. Information stated, "The outcome of the drill was worrying in its entirety". Action identified was to repeat the drill as soon as possible. We asked the operations manager if this had been done. We were told this had not. We were told training in fire safety was being rolled out as part of the new induction programme, which was to be completed by all staff. However current training records showed only 23 of the 48 staff employed had completed fire safety training in the last 2 years.

The home had updated their 'business contingency plan'. This provided staff with relevant information and emergency contact numbers for contractors should an emergency arise. Personal Emergency Evacuation Plans (PEEPs) had also been completed for everyone living at the home. This information was kept on people's care files. However these were not easily accessible in the event of an emergency. We also found that the resident list displayed on the wall was not accurate and some of the bedroom numbers had been changed, which had not been reflected on the floor plan kept near to the fire panel. It is essential this information is accurate so that in the event of an emergency, agencies such as the fire service are not impeded when responding on site.

We looked at the fire risk assessment dated July 2013. Not all areas had been signed off by maintenance staff to show action had been taken. The provider sent us information following the inspection to show these areas had been addressed. We also saw up to date servicing certificates were in place for the electric circuits, gas safety, fire equipment, passenger lift and hoisting equipment. We found that action was required in relation to the lift and hoisting equipment. Confirmation of work had been completed was also sent to us following the inspection.

There was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Systems were not in place to effectively monitor and manage the risks to people's health and well-being so that they were kept safe.

Prior to our inspection we received a copy of an audit carried out by the local authority Infection Control Team in July 2014. The home was assessed as being 45% compliant in maintaining adequate systems within the home to minimise the risk of cross infection to people. Significant shortfalls were found in the hygiene standards maintained in people's bedrooms, bath and shower rooms and poor clinical practices.

During this inspection we looked around the environment including communal areas, bathrooms and toilets, bedrooms, laundry area and the kitchen. We found a malodour in nine bedrooms, stained carpeting and beds in four bedrooms and stained carpeting along the corridors. Clinical items, such as protective clothing used by staff had been disposed of in open bins. One of the lounges on the ground floor, Turner unit, was also affected by a strong offensive odour. We smelt this odour when we had first approached the external front door of the home.

On the second day of the inspection, 28 October 2014, we saw domestic worker cleaning the hall carpet outside the main office. Whilst a carpet cleaner was available, the domestic worker was using a mop and cleaning liquids to wash the carpet. When asked, the domestic worker told the inspector that the carpet cleaner did not work very well and did not bring up the stains.

Our findings did not demonstrate that the areas of concern identified in the local authority infection control audit had been acted upon by the provider to address the issues. We were told by the operations manager additional domestic staff were to be recruited.

Inadequate

Is the service safe?

There was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We found concerns about the levels of cleanliness and hygiene of the home.

On examination of training records we saw that in the last two years domestic and laundry staff had not received training in areas specific to their role, for example; health and safety, infection control and control of substances hazardous to health (COSHH). Without such training staff may not have up to date knowledge and skills needed to maintain safe standards within the home.

There was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff responsible for maintaining hygiene standards within the home had not received adequate training and development to carry out their role effectively.

Inadequate

Is the service effective?

Our findings

The service was not effective. We asked to see an up to date copy of the provider's policy and procedure on Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We were provided with a draft policy titled 'Deprivation of Liberty and Decision Making'. This policy had been seen following our last inspection in August 2014. Our finding were included in a warning notice dated the 15 September 2014. We found this had still not been updated providing clear and up to date guidance for staff in the Deprivation of Liberty Safeguards.

At this inspection we found appropriate arrangements had been made where people had restrictions in place. We were advised that applications for two people had been made to the funding authority to deprive them of their liberty. CQC had been formally notified by the provider prior to this inspection that applications had been made. During the inspection we saw relevant documentation had been completed however had yet to be considered by the funding authority. Due to this, meetings had been held with relevant health professionals, the person and their relatives, where appropriate, to discuss what intervention was required so that decisions were made 'in the person's best interest'. However Information about the decision was not accurately reflected to guide staff in the agreed level of support required.

On one person's care records we saw conflicting information about their ability to manage their own finances. We were told a budget plan had been put in place to minimise risks to this person however this was not clearly recorded on their care plan. We also saw an entry in the appointment diary stating one person living at the home owed another person some money. We asked the operations manager and deputy manager to explain this as the person who had lent money was not able to verbally express their wishes. Therefore it was unclear how they had consented to this.

We found there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was no up to date guidance for staff to follow and people's records did not identify who and why decisions had been made.

Examination of training records showed that in the last two years only 14 of the 48 staff employed at the home had received training in MCA and DoLS. We spoke with a new member of staff, who according to training records, had completed training in MCA and DoLS in August 2014. However when asked, they told us they had not yet completed the course and had no understanding of the MCA and DoLS procedures. This meant either records were inaccurate or staff had not understood the training provided. Training in MCA and DoLS should help guide staff in the delivery of good practice so that people's rights are promoted and protected.

We were told by the operations manager the provider used an external training provider who facilitated training at the home. Records showed induction training took place over six days and included 11 areas of training, such as moving and handling, health and safety, food hygiene, first aid and safeguarding adults. New staff spoken with told us they had completed this training prior to working with people. One person said this had helped them understand what was expected of them. We looked at the staff training records. Information confirmed what we had been told by new staff. We found suitable arrangements had not been made for existing staff to renew these areas of training for some time.

The primary needs of people living at Parklands House were either a mental health condition or dementia. We saw staff had little interaction with people. Training records showed that since 2012 only 10 staff had received dementia care training and four staff had completed training in the Mental Health Act. People were at risk of not receiving safe and effective care as staff did not have the knowledge and skills needed to support the specific needs of people living at the home.

We asked staff if opportunities were provided for them to talk about their work, for example team meetings and individual supervision meetings. We were told by two of the care assistants that two recent staff meetings had been held in July 2014 and October 2014. One of the meetings had included senior management and the provider. Issues discussed included the recent inspections by CQC, issues and concerns about the quality of care people received at the home as well as the action needed to make the necessary improvements. We saw minutes to support what we had been told. Staff said they had not yet received individual supervision however said they could speak with more experienced staff if they were unsure about anything.

Inadequate

Is the service effective?

There was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Not all staff had the knowledge and skills they needed to safely and effectively deliver the care needed.

The records for two people showed one person had lost 7kg of weight over a period of five weeks and the second person had lost 12kg over a three week period. There was no information to show that any action had been taken to address the weight loss, such as a referral to their GP or to a dietician.

We looked at how people were supported in meeting their nutritional needs. One person told us they had complained about the choice of food offered. This was confirmed by the chef and activity worker. We were told that due to this and other comments received the chef had met with people to discuss what meal options they would like. Menus were being reviewed to include suggestions made by people. Whilst weekly menus were not displayed, daily menus were written on a chalk board near to the large dining room. People were offered two meal choices for both lunch and the evening meal.

We spent time in the dining rooms observing the lunch time period. We saw those people who required assistance with their meal were supported on a one to one basis. Staff were seen to be patient and mealtimes were unhurried. Where necessary some people used a plate guard to promote their independence. We heard one person ask for the vegetarian option, once eaten they commented, “That was delicious”.

We asked the chef how they were made aware of people’s specific dietary needs. We were told that staff would identify on the daily meal choice list if someone required a pureed diet. The chef did not have written guidance where people had been assessed by the dietician or speech and language therapist. Without this information people were at risk of not having their nutritional needs met.

It was identified from care records that five people had swallowing difficulties and required thickened fluids. Thickeners are added to drinks and sometimes to food for people who have difficulty swallowing as they may help prevent choking. Information had not been clearly relayed to staff and care records were not easily accessible as they were kept in a locked office. We saw that people were not given the correct consistency of fluids and staff spoken with were not able to tell us the correct consistency required for each person. Failing to provide people with the correct prescribed consistency of fluid placed them at risk of choking.

We found that there were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This was because people’s health needs were not met as potential health concerns were not always identified and acted upon. People were not protected against the risk of receiving unsafe or inappropriate care.

Inadequate

Is the service caring?

Our findings

People were not cared for in a dignified way. People living at Parklands House have varying needs and abilities. For those people not able to tell us about their experiences, we spent some time observing the lunch time period to see how they were spoken to and supported by care staff. From our observations we saw staff speak with people in a pleasant and friendly manner.

We saw people on the ground floor spent time in the lounges. People were either sat quietly or were asleep. Staff gave people little attention unless assisting with specific tasks such as; having their meal or going to the toilet. There was little or no communication and little effort was made by staff to sit by people or undertake any activities with them. Following our inspection we received further feedback from the local authority advising us of similar observations made of staff during their most recent visit to the home.

Some of the people we spoke with did not wish to answer specific questions about the care and support they received. Three people were happy to talk with us. One person told us; I'm settled here" and "I want to stay here". Their relative told us; "It's a good clean home" and "The carers are lovely". Another person seen moving around the building said; "If I go up they [staff] tell me to come down, if I come down they tell me to go up...I don't know what I'm doing". A third person said; "I'm alright here, I've been here a long time".

We saw several people looked unkempt and were seen wearing soiled, mismatched or ill-fitting clothing and their hair was untidy. The relative of one person told us they were not happy their relative was sometimes wearing soiled clothing and not been assisted by staff to change them. They said their relative was a 'proud man' and would not like to be dressed that way. They added, "It's not very dignified". They also said they were concerned about staffing levels and how this was impacting on people. They said they intended to speak with the deputy manager whilst at the home.

We saw signs displayed in people's bedroom asking staff to help people clean their teeth or make sure their glasses were worn. One relative commented; "He's not got his glasses on, they are not in his room and he would normally wear them, he can't see the television". Whilst looking in people's rooms we found some people had no items for oral care, or toothbrushes were unopened or unused. We also found in bedrooms people's care needs were displayed on the wall. In one room information displayed related to someone else and not the person whose room it was. This did not demonstrate people were supported in a dignified way.

We saw people's records, such as observational charts or dietary records were kept in the lounge areas. Whilst these were easily accessible for staff to complete, they were not stored securely to ensure information about people was kept confidential.

We saw people had access to suitable walking aids, such as walking sticks and frames to promote independence. Where necessary some people were assisted with the aid of a hoist.

We were aware review meetings were taking place with people at the home. People had been involved in the meetings, where possible and were able to express their views. Those not able to express their needs and wishes were supported by relatives, where appropriate, or independent advocates had been sought so they could speak on behalf of people.

We found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not always supported in a way which promoted their dignity, choice and independence.

Inadequate

Is the service responsive?

Our findings

The service was not responsive to people's changing needs. People's records showed their needs were assessed prior to admission to the home. Information had been used to develop a care plan about what support people needed.

People's care records did not reflect their preferences and how they wished to be cared for. For example; people's routines, rising and retiring and likes and dislikes were not recorded.

We looked at the care records for six people and found they did not contain enough information to show how people were to be supported and cared for. One of the care records showed the person had a specific medical condition, which required medication and monitoring. There was no information in the care plan to guide staff about aspects of the person's health that could be affected by this condition. During our inspection we were made aware that this person had become unwell. The agency nurse on duty responded to the emergency in a timely and skilful manner. The agency nurse told us that, although she knew what action to take, there was no information in the care record in relation to the aftercare of the person following an emergency. We looked at the care record and saw that what the agency nurse had told us was correct. The care record lacked the necessary information to ensure the health and welfare of the person was protected.

We looked at the records for another person. We were told by the deputy manager this person had recently received hospital treatment due to changes in their health. Changes in the person's health had not been reflected in the care plan advising staff of the person's changing needs and action being taken to address this.

One person we spoke with said they were 'frightened' because of another person's behaviour. On two occasions we asked the deputy manager and operations manager to intervene due to the heightened anxiety and agitation displayed by this person and the impact this potentially had on other people in the home. We spoke with the deputy manager about the current needs of people, we also spoke with staff to check out their understanding and reviewed people's records. Not all staff clearly understood people's individual needs and how they wished to be cared for. Records did not reflect what we had been told.

There was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risk of unsafe or inappropriate care as care records for the planning and delivery of care did not ensure the safety and welfare of people.

We looked at how people spent their time and spoke with the activity worker. Activity staff told us that a morning meeting was held each day with people on the first floor. People were able to talk about anything they wished to as well as being told what activities were available. Activity staff told us one person had enrolled in a college course and several people enjoyed visiting the local park opposite the home.

We found most people were not provided with suitable activities offering variety or stimulation in their daily routines. People living on the ground floor had more physical needs and required help from staff. Those people on the first floor were more able and independent in addressing their needs and making decisions. In each of the communal areas music was playing or the television was switched on by staff however most people, particularly on the ground floor units, did not engage with this.

We saw one person knitting and two people had visitors. A number of people spent their time coming in and out of the building whilst they smoked, whilst other people, particularly those downstairs, spent the majority of time sat sleeping. When staff were not assisting people with their care needs, we saw them sat observing people in the lounge areas but not engaging or initiating conversation with people.

A look at the activity trackers showed meals and personal care tasks were recorded as an activity. Other entries included playing pool, music, DVD, tuck shop, arts and crafts and fresh air. These were generally offered to those people on the first floor however some people refused to take part. The activity worker told us they were developing their role and whilst they had previously worked with people with mental health needs, they had little understanding of the needs of people living with dementia.

We found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People social, emotional and cultural needs were not considered to ensure their autonomy, independence and choice were promoted.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. The home does not have a registered manager. We had been told by the provider that interim arrangements had been put in place. We were told the operations manager would be providing full time cover at the home and would be supported by the deputy manager.

We spent time speaking with the deputy manager and operations manager and checked records to see what systems had been put in place in relation to the management and conduct of the service.

We saw the provider had introduced a number of quality monitoring audits. These included areas such as medication, staff induction, supervisions, care standards, cleaning procedures, bed rails, mattresses, accidents and incidents, people's weight, pressure care, finances, complaints, training and rotas. Certain areas were identified for review on a weekly or monthly basis. On examination of records we found that audits had not been completed in all identified areas. Of those audits completed, where action had been identified there was no evidence to show appropriate action had been taken. For example; a monthly bed rail audit had been completed on the 24 September 2014 by the deputy manager. The record stated that risk assessments were in place. However care records looked at for two people who used bedrails had no assessment in place. This means that audits were not undertaken thoroughly enough and questions asked were not correctly answered.

Monitoring of people's care records to check that information was accurate and up to date were inadequate. Examination of eight people's care records showed these did not reflect what we had been told by care staff about the person's current and changing needs. An internal care plan audit had been completed in October 2014 on six care files. Omissions were identified however there was no evidence of action being taken to make the improvements needed. We also saw two medication audits completed in September and October 2014. On the September audit the operations manager identified action required, including the implementation of weekly audits. On the October 2014 audit further discrepancies were identified. Again there was no evidence of action taken or that weekly audits had been implemented.

Prior to our inspection we received information from the local authority Infection Control Team. They had completed an audit of the service in July 2014, which highlighted improvements were needed to ensure the risks of cross infection were minimised. From our observations and information seen during the inspection this did not demonstrate this had been done.

We saw that feedback surveys had been distributed to people living at the home, asking them to comment on the care and support they received. We saw six people had responded. Feedback varied between 54% to 86% positive comments. Again there was no evidence to show that people's views had been considered and discussed with them or changes made to the service delivery. We did not see how the provider sought the views of those people who were unable to express their views or were unable to complete the surveys.

Whilst the provider used The Regulation and Quality Improvement Authority (RQIA) Tool 2009, in determining staffing levels within the home. What we were told did not reflect what we saw on the staff rotas or confirmed by some of the staff and visitors we spoke with.

Due to the current issues and concerns about the conduct of the service the local authority contracts monitoring and safeguarding team were making regular visits to the home. We were told the monitoring team had visited the home following our inspection and were still concerned about the service. This included the lack of clear management, low staffing levels and use of agency staff and medication management. Concerns were also raised about the management and treatment of people's clinical needs. We were told there was a reliance on the community matron to identify and monitor the clinical needs of people. Our findings during this inspection showed that people's changing needs were not effectively monitored or acted upon so people received the intervention they needed in a timely manner.

We found there were breaches in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were not protected from the risk of inappropriate or unsafe care, as systems to assess and monitor the quality of the service were not effective.

Inadequate

Is the service well-led?

Following our previous inspection the Care Quality Commission was now kept informed of any incidents or accidents which occurred at the home, as required by current legislation. These had been received in a timely manner.

Systems were in place for recording and responding to any complaints or concerns. Records were maintained of any issues brought to the manager's attention along with action taken.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People's safety was being put at risk as the medicine management system did not demonstrate people received their medicines as prescribed.**

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Suitable arrangements to effectively maintain hygiene standards within the home and minimise the risk of cross infections were poor.**

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records **Accurate records about the individual support needs of people were not maintained. Care records did not reflect how people were being restricted, how risks were managed or reflect their changing health needs.**

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were not always able to tell staff if they needed help. People were reliant on staff to identify any change in their health and well-being and seek appropriate help and advice. We saw where people had lost a significant amount of weight loss, this had not been acted upon. This could result in people's healthcare needs not being met.**

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People did not receive care and support that was delivered in a dignified and timely manner. Visitors to the service told us they had witnessed people having to wait for assistance and they looked unkempt. They said people were left without staff supervision and had to seek out staff when people needed assistance. We saw staff did not always provide meaningful interactions with people.**

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

This section is primarily information for the provider

Enforcement actions

People were not always supported by sufficient numbers of staff to keep them safe. Due to the turnover in staff there had been a reliance on agency staff to support people. We found these staff were not aware of the individual needs of people.

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers Systems to monitor the quality of the service were not robust. Where audits had been completed and areas of improvement had been identified, the provider could not show us that appropriate action had been taken to improve the quality of service people received so that they were kept safe. This put people at risk of harm or injury.

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Effective management arrangements providing clear leadership and support for staff were not in place. New staff spoke positively about working at the home and the support they had received from colleagues. However existing staff had not received updated training and support in areas specific to the needs of people living at Parklands House.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **Staff recruitment processes had improved however not all checks about the suitability of staff had been completed prior to them commencing work. This puts people at risk of being cared for by staff that are unsuitable to work with vulnerable people.**

The enforcement action we took:
Under Section 12 (5)(a) of the Health and Social Care Act 2008 we have removed Parklands House Care Home, 87-89 Falinge Road, Rochdale, Lancashire, OL12 6LB, as a location condition of registration for the service provider, Eldercare (Halifax) Limited in respect of the above regulated activity at or from the following location.