Hometrust Care Limited

Carlisle Dementia Centre - Parkfield

Inspection report

Carlisle Dementia Centre (Parkfield)
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Date of inspection visit:
03 February 2021
09 February 2021
02 March 2021

Date of publication:
02 August 2021

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Carlisle Dementia Centre - Parkfield is a care home providing personal and nursing care for up to 44 people. At the time of the inspection, there were 28 people who were living with dementia or mental health needs accommodated at the home.

People's experience of using this service and what we found
Staff did not always follow the correct infection control practices including the use of PPE and hand hygiene. This placed people at risk of infection which is a concern during this time of a national pandemic.

Staff did not consistently follow safeguarding processes, and incidents were not always reported to the safeguarding authority.

Records of prescribed topical medicines were not completed. Some care records were poorly completed and did not demonstrate how risks were being effectively managed.

The provider's quality systems within the home were not effective. There were gaps and inconsistencies in a number of care records.

People were not always supported to have maximum choice and control of their lives. Staff supported them in the least restrictive way possible and in their best interests; however, the systems in the service did not always demonstrate this practice.

People we spoke with told us they liked the staff and we saw people were comfortable and engaged with staff. Staff were patient and friendly towards people. Relatives said their family members were settled and happy in the home.

Staff had essential training and relatives said they were confident in their skills at supporting people who were living with dementia.

People and relatives said they got enough to eat and drink. People were offered meals in a way they could manage and given choices of different dishes.

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 23 October 2018).

Why we inspected
We received concerns in relation to a safeguarding matter. As a result, we undertook a focused inspection to

review the key questions of safe, effective and well-led. After the initial inspection visits, we received concerns about financial matters, so we carried out another visit. We found no evidence of financial misappropriation.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Carlisle Dementia Centre - Parkfield on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection control, safeguarding and quality assurance.

Please see the action we have told the provider to take at the end of this report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Carlisle Dementia Centre - Parkfield

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.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Carlisle Dementia Centre - Parkfield 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. We used all this information to plan our 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 took this into account when we

inspected the service and made the judgements in this report.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with seven members of staff including the registered manager, a nurse, senior care workers, care workers and administrative officer. 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 five people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We reviewed a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We contacted with two professionals who are involved with people who use the service.

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.

Preventing and controlling infection
● A safe and effective infection control system was not fully in place to ensure people were protected from the risk of infection.
● Staff did not always wear PPE correctly and did not always follow current government guidance regarding how to put on or take off PPE.
● Some areas of the premises could not be kept hygienically clean, for example frequently touched worn surfaces and grubby light pull cords.

People were not always protected from the risk of infection. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● After the inspection the provider sent an action plan detailing how infection prevention and control would be addressed.

Systems and processes to safeguard people from the risk of abuse
● The provider's safeguarding systems were not consistently followed. It was not always evident that actions had been taken to protect people. Several potential safeguarding incidents had not been reported to the Commission.
● Safeguarding incidents had not been referred to the local safeguarding authority. There was no evidence that strategies were put in place to minimise the risks of recurring events. For example, several similar incidents had occurred between the same people over different dates.

Safeguarding systems were not robust enough to protect people from recurring incidents of potential harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Most relatives said people were safe at the home. Their comments included, "I know [my family member] is safe there and seems happy" and "Staff have a good rapport with [my family member] and they are settled and comfortable."
● After the inspection the provider stated staff would be retrained in safeguarding processes and there would a weekly management review of daily reports to identify any reportable events.

Using medicines safely
● Medicines were not always managed in a robust way. It was not clear if people had received support with

the topical medicines they were prescribed. For example, some people had creams applied but staff did not record the administration of prescribed creams.
● There were no guidance records to describe how, when and where staff should apply these types of topical medicines, so it was not clear if this was in line with directions of the prescriber.

The failure to maintain appropriate records in respect of the management of prescribed topical medicines is a breach of Regulation 17 (Good governance) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Oral medicines were administered appropriately. Staff were trained in safe management of medicines and their competence was routinely checked.

Assessing risk, safety monitoring and management
● People's care records contained evidence that individual risks were reviewed and updated.
● Safety checks relating to fire and lifting equipment were carried out by external contractors and were up to date.
● The home did not have dedicated maintenance staff. Some routine checks, such as cleaning extractor fans to prevent a fire hazard, had not been carried out regularly. The provider addressed these matters immediately.

Staffing and recruitment
● There were enough staff on duty to meet people's needs.
● Relative were complimentary about the "amazing staff team" and many were familiar with staff by name.
● The provider had systems for the safe recruitment of staff. Sufficient checks were carried out prior to appointments to ensure staff were suitable to work with vulnerable people.

Learning lessons when things go wrong
● The service had a system to record accidents which were reviewed by the registered manager to identify trends. The registered manager analysed this information to check whether there were any trends.
● The analysis did not include the actions taken to improve people's safety and to prevent recurrence, for example where there was an increased risk at certain times of the day so additional staffing was required. The registered manager said she would include actions taken in future analyses.

Requires Improvement

Is the service effective?

Our findings

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

At 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 effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were assessed before they started to use the service. The assessment decided whether their care could be met.
- People's needs were set out in care plans. In some cases, significant events had not led to an effective evaluation of people's needs to check if the person needed additional support. For example, care plan evaluation for people who had experienced a significant increase in behavioural incidents stated, "care plan remains valid" and did not guide staff in providing additional support.

The incompleteness of care records is was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection the provider told us a care plan audit had been carried out to address these shortfalls. An IPC nurse also carried out an audit of the home and worked with the registered manager to look the remaining actions that were to be taken.

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.
- The provider had processes to consider whether decisions were made in the best interests of people who lacked the mental capacity to make specific decisions.
- There was information about people's DoLS status in their individual files. The registered manager reviewed all new DoLS applications on a six weekly basis due to the local authority's backlog in approving these.
- Records about mental capacity and decision-making were inconsistently applied. Staff had completed assessments about some restrictions but not others. For example, there were no records of best interest

decision-making processes around the use of bedrails. This meant it was not always clear whether this was considered the least restrictive option and who had been involved in the decision.

We recommend the provider reviews records relating to best interest decision-making to make sure these appropriately in place.

Adapting service, design, decoration to meet people's needs
● There was no dementia strategy that set out the standard of service expected to be provided to people living with dementia.
● There was little in the way of visual orientation for people except for some pictures on toilet doors. For example, most bedroom doors had no objects of reference, such as numbers or pictures, for people to find their own room. An information blackboard in one unit had the wrong day and date on.
● The registered manager stated a staff member had previously been appointed to review the dementia design of the premises, but they were no longer in post.

We recommend the provider seeks best guidance about dementia design to support people's orientation and independence.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to ensure their health and wellbeing. We observed the lunch experience. Staff were attentive to people's needs and encouraged them with their meals and drinks, offering alternatives if they did not appear to enjoy what was presented.
● Staff recorded the amount of food and fluids of people if they had been assessed as being at risk of malnutrition or dehydration. People were weighed regularly to ensure any weight loss could be identified.
● People and relatives who took part in this inspection said people were offered enough to eat. A relative commented, "They feed [my family member] very well." We observed that portions were generous and looked appetising.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The service made referrals to health care professionals to support people's health needs. People and relatives said they were supported to see health professionals if required.
● Care professionals had mixed views about the whether the service worked collaboratively with them. Their comments included, "They are pretty good in clinics and some of the care staff are excellent", "Some staff are willing to try suggestions" and "Sometimes they seem reticent to take advice".

Staff support: induction, training, skills and experience
● Staff received essential training to undertake their role. Relatives said staff were "good" at their jobs and said they understood how to "deal with people's frustration and behaviours."
● New staff received induction training and completed a care workbook.
● Staff received supervision to help develop their performance. Staff told us they felt their supervisors were "supportive".

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. This did not always support the delivery of high-quality, person-centred care.

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

- The provider's quality systems within the home were not robust. The gaps and inconsistencies in a number of records indicated ineffective governance by the provider.
- Care evaluation records were not updated when changes occurred. There were no records kept of the application of prescribed topical medicines. Staff were not checked for their competency in wearing PPE. Mental capacity assessments were missing for some restrictive equipment such as bedrails
- The registered manager undertook a range of quality checks and audit processes. However, these had not identified the shortfalls we found to practices and records.

The ineffective governance was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The provider understood their obligations in relation to duty of candour, including being open and transparent when incidents had occurred. However, not all CQC reportable incidents had been notified in line with the registered provider's legal requirements.

The provider had failed to report all legally notifiable incidents to the CQC. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

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

- Staff demonstrated a commitment in providing person-centred care to people.
- Relatives told us that care support staff tried hard to meet people's individual needs. Their comments included, "Staff know how to support [my family member] and they know all the staff" and "This is the only place they have ever settled in and they are happy."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Most relatives who took part in this inspection felt they were kept informed with any relevant information

about their family member. One relative described having video meetings to discuss their family member's well-being. Another relative said, "They often ring me and let me know what's going on, and they've explained care pathways to me."

● Staff had meetings and said they were kept informed of organisational expectations and standards.

● Care professionals had mixed views about working in partnership with the service. Some commented it could be hard to get a response to telephone calls.

Continuous learning and improving care

● Relatives commented that the home was "a bit chipped and worn".

● The provider was committed to improvement of the home and service. They had upgraded one unit and had plans to refurbish the remainder of the environment.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding processes were not always followed to ensure people were protected from abuse. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to ensure compliance with the regulations. The governance systems in place were not robust enough to identify shortfalls in quality and safety. The provider failed to ensure the service was assessed and monitored to improve quality and safety. Regulation 17 (1)(2)(a)(b)(e)(f).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	An effective system was not in place to assess, prevent, detect and control the spread of infection. Regulation 12(1)(2)(h).

The enforcement action we took:

We have issued an urgent Notice of Decision to impose conditions on the provider's registration.