Pridell Care Limited

Care at Parkside

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Care at Parkside is a care home that provides 24-hour residential care for up to 24 people. At the time of our inspection there were 18 people living there. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home is situated approximately one mile from the centre of Oldham. It is a large detached property which has been extended to the rear and provides accommodation over two floors. It has a garden to the front and rear of the property and a small car park.

This was an unannounced inspection which took place on 7, 8 and 9 November 2018. The CQC has previously inspected Care at Parkside twice; in August 2016 and February 2018. Both times it has been rated as Requires Improvement, overall.

The service has a history of non-compliance with meeting the regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. At our inspection in August 2016 we found breaches of three regulations relating to training, risk assessments, care plans and governance of the service. The provider was issued with requirement notices and asked to complete an action plan telling us how they would make improvements.

We next inspected the home in February 2018. At that inspection, although we found there had been an improvement in the training the service provided to staff, we again found concerns relating to risk assessments, care plans and the governance of the service. In addition, we found concerns relating to fire safety, maintenance of the premises, infection control and medicines management. This meant the service was in breach of regulations 12, 15 and 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. We issued warning notices for breaches of regulations 12 and 17 and a requirement notice for the breach of regulation 15. The provider completed an action plan to show how they intended to improve the service.

At this inspection we found improvements had been made in some of these areas. However, we identified shortfalls in the management of medicines, recruitment practices, the management of risk, infection control and governance. The service remains in breach of regulations 12 and 17 of the Health and Social Care Act (2008) Regulated Activities 2014. We have also identified a breach of regulation 19 of the Health and Social Care Act (2008) Regulated Activities 2014. This is because of poor recruitment practices.

We have made three recommendations. These are that the service seeks further guidance around the assessment and documentation of mental capacity and best interest decisions and that they ensure there is a suitable qualified member of staff to carry out moving and handling training and assessments. We have also recommended the service seek further guidance around equality and human rights.

Over the three inspections the CQC has carried out at this service, we have found repeated breaches of the regulations. The provider has failed to maintain and improve the standard of care at the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will act to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Following this inspection, we met with the provider to discuss the steps they intend to take to improve the service. We have received assurance that some of the concerns we identified have been addressed and we will review these at our next inspection. However, further improvement is needed at this service.

At our last inspection in February 2018 the service did not have a registered manager. Since then the former deputy manager of the home has become the 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found that safe recruitment practices were not always followed. Two staff had been employed without any references.

Medicines were not always managed safely. During our inspection we identified an error in the documentation used for the administration of a controlled drug. Although no harm came to the person, staff had failed to follow the correct administration procedure. Protocols to guide staff on how to administer 'when required' medicines were not being used.

Risks to people's health and safety had not always been identified. One person who had been at the home for two weeks did not have any risk assessments in place, for mobility or falls. This person was frail and struggled to walk without help. No risk assessment had been completed before flooring contractors started work in the building. On two occasions we found tools and equipment were accessible to people living at the home. This put their safety at risk.

Since our last inspection there had been some redecoration of bedrooms and new flooring was being laid throughout the communal areas. The lounges and dining rooms were nicely decorated and furniture was a decent quality. However, further redecoration is needed to improve the condition of the downstairs bathroom. Infection prevention and control measures had improved since our last inspection. However, we observed one care assistant undertaking medicines administration without first washing their hands.

Checks and servicing of equipment, such as for the gas, electricity and fire-fighting equipment were up-to-date. However, we found regular maintenance checks to prevent legionella were not being carried out.

There were systems in place to help safeguard people from abuse. Staff understood how to identify signs of abuse and what action to take to protect people in their care. At the time of our inspection there were sufficient staff to support people. However, the registered manager did not have any time allocated specifically for managerial work, as they were usually counted as part of the care team. We found the home was poorly managed.

Staff had undergone training to ensure they had the knowledge and skills to support people safely. All staff received regular supervision. This ensured the standard of their work was monitored and gave them the opportunity to raise any concerns.

Deprivation of Liberty Safeguards (DoLS) were in place where necessary. Staff sought consent from people before helping them with their care needs and people were helped to make choices about everyday routines, such as what to wear and what to eat. However, care records did not always contain information to show people had been involved with planning and reviewing their care where they had capacity to do so. When they lacked capacity, it was not always recorded who was involved with helping them make important decisions.

We received positive comments from people about the staff and about the care provided at the home. Staff supported people to take part in some activities. People were supported to eat a well-balanced diet and were offered a choice of meals. Staff worked with health and social care professionals, such as district nurses, to ensure people maintained good health.

We found a continued problem with the lack of detail and accuracy in some care records. This meant staff did not have the correct information about how they should support people.

The service had a process for handling complaints and concerns. No complaints had been received since our last inspection. The registered manager told us she dealt with any minor concerns when they happened to prevent them from escalating.

Very few quality monitoring checks had been completed since our last inspection, despite the service having an audit schedule, and we found there was a lack of oversight of the service. After our last inspection in February 2018 the provider submitted an action plan telling us how they would make improvements to the service. Although the action plan was completed, we found at this inspection that some of the improvements have not been sustained and we have identified further concerns about the service and how it is managed.

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.

People's medicines were not always managed safely.

The provider did not follow safe recruitment procedures.

Risks to people's health and safety were not managed properly. People were therefore put at risk of harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received training and supervision. However, we have made a recommendation about the provision of moving and handling training.

People were provided choice and supported to make decisions about their everyday routines.

People were supported to maintain their nutrition, health and well-being. Staff worked with other health care professionals to meet people's health needs.

The service worked within the principles of the Mental Capacity Act (2005). However, we have recommended they seek further guidance about making and recording decisions about mental capacity and best interests.

Is the service caring?

Good

The service was caring.

We received positive comments about the staff and about the care they provided.

People were treated in respectful way.

People were given choices about everyday decisions, such as what to wear and eat and when to get up. People were supported to be independent.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans were not detailed enough or accurate. This meant staff did not always have the correct guidance to provide person-centred care.

People were supported by staff to take part in some activities.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had failed to ensure the newly appointed registered manager was supported adequately in their role.

There was an on-going failure of the provider and registered manager to ensure the quality of the service was monitored and improved. Most audits had not been completed.

Although some action had been taken following our last inspection to improve the service, this had not always been sustained and we found further concerns around how the service was managed.

Care at Parkside

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. The inspection was planned to check 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 was an unannounced inspection which took place on 7, 8 and 9 November 2018.The inspection was carried out by an adult social care inspector. We inspected Care at Parkside in response to some concerns, brought to our attention by the local authority. These were around staffing and the nurse call bell system, which was not working in nine out of 18 bedrooms. The nurse call bell system is how people summon assistance when they are in their bedrooms.

Before the inspection we reviewed information we held about the service. This included the statutory notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send to us without delay. We also reviewed the inspection reports from our last two inspections of the service, which were in August 2016 and February 2018.

During our visit we spoke with the registered manager, the administration manager, two senior care assistants, a care assistant, an apprentice and the cook. We also spoke with two people who used the service and two relatives. We looked around the home, checking on the condition of the communal areas, some bedrooms, toilets and bathrooms, laundry and kitchen. We observed the lunchtime meal and the administration of medicines.

As part of the inspection we looked in detail at three sets of care records. These included care plans, risk assessments, daily notes and monitoring charts. We also looked briefly at other care files. We reviewed the medicine administration records (MARs). We looked at other information about the service, including training and supervision records, five staff personnel files, audits and maintenance and servicing records.

Inadequate

Is the service safe?

Our findings

At the last inspection in February 2018, we rated 'safe' as 'Requires Improvement'. We found the provider was in breach of regulations 12 and 15 of the Health and Social Care Act 2008. We found concerns around the management of risks to people's health and safety, medicines, infection control, maintenance of the premises and fire safety. We issued a requirement notice for the breach of regulation 15 and a warning notice for the breach of regulation 12. The provider submitted an action plan describing the improvements that they would make to comply with the regulations. At this inspection, although we found some improvements had been made and the provider was no longer in breach of regulation 15, we identified further concerns in relation to the safe care and treatment of people. The provider continues to be in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This ongoing failure has contributed towards the rating of 'Inadequate' in the 'safe' domain.

We reviewed five staff personnel files to look at the recruitment process. We were told it was the responsibility of the administration manager to ensure that all recruitment documents had been obtained prior to new staff taking up their employment at the home. Each file contained an application form, photographic identification and a Disclosure and Barring Service (DBS) check. However, two of the files did not contain any references and another two files contained only one reference. The administration manager told us they had emailed a reference request to one of the referees but had not received a reply. No further attempts had been made to secure references for these members of staff, who were currently working at the home.

Failure to carry out adequate recruitment checks is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

During our inspection we asked the administration manager to obtain references for these employees and we have received reassurance that these are now in place.

We looked at the management of medicines. At our last inspection in February 2018 we found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because medicines were not always managed safely. At this inspection we again found concerns in this area.

On the first day of our inspection we watched a senior care assistant giving out medicines at lunchtime. Although they signed the medicine administration records (MARS), which indicated that people had taken their medicines, we observed that they did not actually stay with them to ensure they had taken their medicines.

We checked how the service managed controlled drugs. These are prescription medicines controlled under the Misuse of Drug legislation e.g. morphine, which require stricter controls to be applied to prevent them from being misused, obtained illegally and causing harm. We looked at the register where the names and amount of each controlled drug stored in the home's controlled drug cupboard are recorded. Guidance provided by The Royal Pharmaceutical Society of Great Britain in 'The handling of medicines in social care'

states 'include the balance remaining for each product. This should be checked against the amount in the pack or bottle at each administration and also on a regular basis, e.g. monthly'. We found that although the balance was checked each time a controlled drug was given, a regular stock check of the balance was not carried out, as is recommended in the guidance.

We counted the stock balance of one person's controlled drug and found there was a discrepancy between the number of remaining tablets and the number recorded in the controlled drugs register. We counted 32 tablets remaining, however 33 were recorded in the register. Through our discussions with the registered manager and with staff, we identified that a care worker had given a person their prescribed tablet, four days prior to our inspection, without following the correct safe administration and recording procedure. This had led to the stock balance being incorrect. The medicine had been given a further eight times since the original error and each time the balance should have been checked. However, no one had identified that there was a discrepancy in the recorded balance and the number of tablets that remained. This medicines error was reported to the person's general practitioner and to the local authority safeguarding team and the care worker immediately received re-training on medicines administration. No harm came to the person who received the medicine. However, failure by staff to identify the counting discrepancy on repeated days shows the service did not have an adequate system in place for checking the stock balance.

We reviewed the MARs, which contained information necessary for the safe administration of medicines, such as people's allergies and a photograph of the person. This information helps the person administering medicines give them to the right person. We found the MARs had been completed correctly, which showed people had received their medicines as prescribed. At our last inspection we found six records did not have a photograph of the person. At this inspection we found two photographs were missing.

At our last inspection we found that people did not have the necessary documentation for safe administration of medicines to be taken 'as required', such as pain relief or inhalers for respiratory problems. This documentation helps staff to recognise symptoms which would indicate that the medicine is needed. At this inspection we again found this documentation was not in place.

The poor management and administration of medicines presented a risk to people's health and safety. Therefore, the service remains in breach of regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The proper and safe management of medicines.

At our last inspection we found that on occasions there were no staff on duty at night who had received medicines training. At this inspection we found that all staff (apart from apprentices) had received medicines training. However, we found that on two occasions an apprentice care worker, who had not received any medicines training, had witnessed the administration of a controlled drug. The Royal Pharmaceutical Society guidance 'The handling of medicines in social care' states, in relation to the administration of controlled drugs, 'in residential settings it is good practice if a second appropriately trained member of staff witnesses this process'. We have been assured that apprentices will not be involved with medicines in the future.

We looked at the systems in place to prevent and control the spread of infection. The home had received an infection control audit by the local authority in August 2018 and scored an overall rating of 95%. At our inspection in February 2018 we found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because effective infection control measures were not in place. At this inspection, although some improvements had been made, we again found concerns around infection control. We looked in the laundry where the leaning mops and buckets were kept. Two mops had been left in the cleaning buckets, rather than hung up to dry after use. Wet mops are prone to bacterial growth. There

was no toilet paper in either of the downstairs toilets and no paper towels by the downstairs sink.

There was an adequate supply of personal protective equipment, such as disposable gloves and aprons and we observed staff using these during our inspection. Antibacterial hand gel was available at different points throughout the home.

The Royal College of Nursing (RCN) guidance on hand hygiene states, 'regular and effective hand hygiene is the single most important thing you can do to protect yourself and others from infection'. During our inspection we observed a care assistant administer medicines without first washing their hands or using hand gel. They moved from helping one person with their lunchtime meal to giving out medicines to other people and did not wash their hands between these two activities. The RCN hand hygiene guidance states, 'you must always wash and dry your hands before and after any contact with the patient/client'.

The issues we found in relation to infection prevention and control demonstrate a continued breach of regulation 12(1) (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Assessing the risk of, and preventing, the spread of infections.

We looked at how the service managed risks which might cause people harm. At our last inspection in February 2018 we found that although people had been assessed for risks, such as from pressure ulcers or from falls, some specific risk assessments had not been carried out. For example, there were no risk assessments for people who smoked. At our inspection in August 2016 we found that risk assessments were not always accurate. At this inspection we found further concerns in how the service managed risk.

We looked at the care file for one person who had been living at the home for two weeks. They were very frail, had limited mobility and needed the assistance of a member of staff to walk safely. No risk assessments, such as for falls, mobility, pressure ulcers or nutrition had been carried out. Consequently, there was no guidance for staff on how this person should be supported and any risks to their health and safety minimised. We found a record in the accident book that showed this person had been 'found on the floor' in the hall way. They had not sustained any injury. However, no falls risk assessment had been carried out before or after this incident. We asked the registered manager to ensure risk assessments were put in place immediately.

The home was in the process of having new flooring laid in the dining room and some bedrooms. On the first day of our inspection, we found that hazardous equipment and material used by the contractors which was stored in one of the main downstairs corridors, was accessible to people living at the home. This included tools, pots of paint, an electric cable, pieces of wood and a door which had been removed and was propped up against the wall. The registered manager told us that there was normally a barrier in front of the equipment to prevent people from accessing it, or falling against it. However, this was not in place. We asked for the barrier to be immediately put in front of the hazards, which it was. Later in the morning we found a hammer, screw driver and a bag of screws left on the floor outside the downstairs toilets. We asked for these to be immediately removed. The registered manager had not carried out any risk assessment in relation to contractors carrying out work in the building to identify potential risks to people who use service and ensure appropriate action to minimise any potential risks to people who use the service.

We carried out this inspection of Care at Parkside in response to some concerns brought to our attention by the local authority, who had visited the home on 22 and 23 October 2018. One of the concerns raised was that the nurse call system, used by people to summon assistance, was not working in nine out of the 18 bedrooms and had been out of action for six to eight weeks. Although the fault had already been identified by staff, no action had been taken by the registered manager to ensure people were checked more

frequently than they normally would (every two hours) during the night or when they were in their bedrooms during the day. On the recommendation of the local authority, the service increased monitoring during the night, to hourly, to ensure people were safe and did not require assistance. Since our inspection we have been informed that a new nurse call system has been installed.

Servicing of equipment, such as hoists and lifts were up-to-date. The annual portable appliance testing (PAT) and legionella bacteria test had been completed. However, we found that regular maintenance checks to protect people against the risk of legionella, which include cleaning shower heads and flushing unused taps, had not been carried out. Guidance from the Health and Safety Executive in 'Health and safety in care homes' suggests that shower heads should be dismantled, cleaned and descaled quarterly and that infrequently used water outlets should be flushed through weekly.

The home was secure. The entrance was kept locked and people could not enter the building without being let in by a member of staff. There was a 'signing in' book for visitors. This ensured staff were aware of who was in the building at any one time.

At our inspection in February 2018 we found the door to the 'COSHH' (control of substances hazardous to health) room was not locked. This meant there was the possibility people had access to chemicals or other substances which could put their health at risk. At this inspection we found this room was locked and secure. However, we found the door to the laundry open on several occasions. This room contained open boxes of soap powder and cleaning equipment. We asked for it to be closed and for a lock to be put on the door.

These findings demonstrate a failure to adequately manage risks to people health and safety is a continued breach of regulation 12(1) (2) (a) (b) and (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked around the home and found it was clean and there were no malodours. At our inspection in February 2018 we found a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment. This was because some areas of the home had not been adequately maintained. At this inspection we found the service was no longer in breach of this regulation, as some improvements had been made. However, further attention is needed to the maintenance of the premise to bring it to a good standard. Since our last inspection some bedrooms had been decorated and those we saw were nicely painted. The downstairs corridors, dining room and lounges were attractively decorated and contained good quality furniture. One bedroom was being refurbished and flooring was being laid in the dining room. However, the downstairs toilets require decorating.

At our last inspection in February 2018 we found people had not been adequately protected from the risk of fire. We referred the service to Greater Manchester Fire and Rescue service, who carried out their own inspection and asked for an action plan to rectify the failings they found. This has been completed.

We looked at the complement of staff employed at the home. The care team was made up of senior care assistants, care assistants and apprentices. In addition to care tasks, they also did the cleaning, laundry and activities. There was also a cook and a maintenance person. People, relatives and staff told us they felt staffing levels were adequate and during our inspection we found there were enough staff to assist people with personal care needs and meals. We also saw that staff had time to socialise and chat to people. One senior carer assistant told us, "There's always time to sit and talk to residents." The home did not use agency staff and gaps in the weekly rotas due to sickness or staff leave were filled by the regular care team.

The staff rotas we reviewed showed that the registered manager was regularly counted as part of the care team. For example, on the first day of our inspection the morning care team was made up of the registered manager, a senior care assistant and a care assistant. On the second day the registered manager, a care assistant and an apprentice covered the morning duties. This gave the registered manager very little opportunity to undertake managerial work. We have discussed this further in the well-led section of this report.

People who used the service and relatives told us Care at Parkside was a safe place to live. One relative said, "The staff are brilliant. I've no qualms about anything." Staff we spoke with understood what was meant by safeguarding, could describe what might alert them to concerns about a person's safety and knew what action to take to report their concerns.

Requires Improvement

Is the service effective?

Our findings

Staff had received training in a range of topics including, infection control, safeguarding, fire safety and medicines management. Training was provided through e-learning courses and work books. Some training, such as moving and handling was given face to face, so that staff could be shown correct moving and handling procedures and how to use equipment, such as wheelchairs and hoists. We found that some staff had received moving and handling training from another member of staff, who did not have a training qualification in this subject. There was a possibility therefore that some staff had not been shown correct moving and handling techniques. However, we did not see any moving and handling during our inspection so we cannot comment any further on the ability of staff to move people safely. The registered manager has informed us they will put forward a senior care assistant to attend a moving and handling 'train the trainer' course. This will give them the skills to carry out moving and handling assessments and teach other staff.

We recommend the service ensure they have a suitably qualified member of staff to teach moving and handling techniques and undertake moving and handling assessments.

From looking at the personnel files we saw that staff had received supervision twice a year. Supervision meetings provide staff with an opportunity to discuss their training needs and progress and to receive feedback about the quality of their work. However, we found that the registered manager had not received any supervision during 2018. This has been discussed further in the well-led section of this report.

People were supported to eat their meals. We observed lunch in the dining room on the first day of our inspection. The majority of people sat together at the dining tables, which were laid with table mats, cutlery, paper napkins and salt and pepper. The atmosphere was calm and there were sufficient staff to serve food and help one person who needed assistance. People ate their meals at their own pace and no one was rushed. We were told of one person who liked to have their meal after everyone else and their request was accommodated. Food looked well-presented and portion sizes appeared appropriate. Where people had been identified as at risk of poor diet or malnutrition, food was fortified with cream, milk and butter to add additional calories. Staff offered people a choice of drinks. The cook told us that people were given a choice of meals and that she spoke to everyone during the day to find out what they would like. People were weighed regularly and referred to a dietician or their GP if they had lost weight. We reviewed people's weights and found that they were stable or increasing.

Following our last inspection in February 2018 we recommended the service review its food charts (where people's food intake is recorded), as there was nowhere to record the quantity of food people had eaten. At this inspection we found more detailed charts were in place. These helped staff have a clearer picture of people's dietary intake. This is particularly important where people are at risk of malnutrition.

People were supported by staff and external healthcare professionals to maintain their health and wellbeing. Care records showed advice and help was sought from healthcare professionals such as GPs and district nurses when appropriate. For example, one person had been referred to the occupational therapy department, as it was felt they might benefit from a specialised chair. People told us they were always kept

informed if there were any changes to their relative's health.

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 make 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection there was only one person living at the home with an authorised DoLS in place. Two applications were awaiting authorisation from the local authority.

We observed that staff always asked people for their consent before providing support. The care records we reviewed had completed mental capacity assessments. However, it was not always clear if people had been involved in writing or reviewing their care plans when they had capacity and where people lacked capacity, it was difficult to see from their care records who was responsible for making decisions about their care.

We recommend the service seek further guidance around the assessment and documentation of mental capacity and best interest decisions.

Efforts had been made by the provider to ensure the environment met people's needs in relation to their physical capabilities. Corridors were wide enough for wheelchairs and communal areas and corridors were well-lit. A passenger lift and stair lift provided access to the first floor for people who were unable to use the stairs. Uneven flooring was marked with hazard strips.

Good

Is the service caring?

Our findings

We received positive comments about the home. One relative told us, "The staff are brilliant. I would never take her anywhere else." People praised the staff. A relative told us, "The staff are very friendly." One person who lived at the home said, "If you need anything from the shop they will go for you." One care assistant told us, "I love my job. I absolutely love it. I love spending time with the residents and getting to know them as individuals. I love making their lives as happy as possible."

We saw people looked well and their personal hygiene needs were met. People's hair looked well-groomed and their clothes clean. Relatives were happy with the way staff maintained their loved one's appearance. One told us, "She's well-dressed and showered, and they do her teeth." Another person said, "She always looks nice."

All staff received training in privacy and dignity. From our observations during the inspection we saw that staff supported people in a patient and respectful manner and we saw caring interactions between staff and people living at the home. However, we saw one instance where a staff member was unthoughtful. During the lunchtime meal we saw them hand round slices of bread to people sitting at the dining tables. They put the bread directly onto the table top and did not offer anyone a plate.

People had some choice in their daily routines, such as the times they got up or went to bed or the time they showered. One care assistant told us "Some residents like having showers in the afternoon." One person chose to get up late and eat their meals on their own. Staff respected their choice and food was kept hot so they could enjoy their meal at a later time. One care assistant told us, "If someone wants a brew, we just make it. There's no set time." People were encouraged to be independent. The home had two comfortable lounges and a dining room and we saw that people moved freely between the different rooms depending on what they wanted to do. During our observation of lunch, we saw that one person was given adapted cutlery which enabled them to eat their meal independently.

Staff were respectful of people's cultural and spiritual needs. An Anglican priest visited the home every six weeks to talk to people and hold a service. There was no one living at the home at the time of our inspection with a non-Christian faith.

Through talking to staff, we were satisfied care and support was delivered in a non-discriminatory way and the rights of people with a protected characteristic would be respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination based on age, disability, race, religion or belief and sexuality.

However, we recommend the service consults the CQC's public website and seeks further guidance from the online toolkit entitled 'Equally outstanding: Equality and human rights - good practice resource.' This recommendation would support the service to fully embed the principles of equality, diversity and human rights across all aspects of the service.

Since our last inspection in February 2018 CCTV had been installed in the home, in the communal areas. There were no cameras in people's bedrooms or the bathrooms. This ensured people's privacy was respected. We were told that use of CCTV had been discussed with people who lived at the home and relatives and that they were happy for it to be in place.

Requires Improvement

Is the service responsive?

Our findings

At our inspection in February 2018 we found that care plans did not always accurately reflect people's support needs. This meant staff did not always have the required up to date information to help them support people in a person-centred way. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found a continued breach of this regulation.

We reviewed three care files in detail and checked care plans in two other files. Each care file was well-ordered and easy to follow. They contained admission information, personal details, risk assessments, a 'support plan in brief' and care plans. Risk assessments and care plans had been evaluated monthly. People had care plans which described how staff should support them, in areas such as nutrition, continence, mobility, communication, personal care and oral care. However, we found some of these were not detailed enough or accurate. This put people at risk of incorrect care, as there was insufficient information to guide staff.

For example, we looked at the mobility care plan and risk assessment for a person who was unable to walk and needed the assistance of two staff whenever they needed to change their position. We found conflicting and inaccurate information in the records. The moving and handling care plan said 'At the moment I am wheelchair bound. I need the help of two care staff when moving and handling. I can stand between two care staff. When transferring I may need to use the hoist'. Staff told us the person was not hoisted, as they were still able to weight bear. However, their care plan had not been changed to reflect this fact. We were told that staff used a moving and handling belt and turn table to help raise them out of their chair (this is good practice). However, there was no information about this in their care plan. This person needed to be turned from side to side when they were in bed, to help reduce the risk of pressure ulcers. There was no information to show how this should be carried out. For example, it is best practice to use a slide sheet to reduce the risk of skin damage during turning. There was no evidence this was being used. One member of staff told us they did not use a slide sheet. Another member of staff told us they thought the person had one in their room, although they could not confirm it was used. Due to poor moving and handling guidance in care plans, there was a risk this person was not being moved safely. We have asked the registered manager to refer them to a moving and handling specialist for an assessment of their needs.

One person needed support with their catheter. Their care plan stated, 'staff to empty (name's) catheter as he is struggling at the moment'. There was no other information to guide staff on the best practice for catheter management, such as hand hygiene, personal care, care of the catheter bags, complications and infection risk.

Some people needed help with personal care, such as showering. Staff recorded when people had showered, on a weekly 'bath record'. We found these were not always completed and some entries were blank. Other records showed staff had recorded 'refused', but there was no indication that they had tried to offer the person a shower on an alternative occasion. We were told of one person who consistently refused help with personal care and was sometimes difficult with staff if they tried to persuade them. However, there

was nothing in their care plan to indicate this behaviour, and how it should be managed.

Failure to have accurate care records is a continued breach of regulation 17 (1) (2) (b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the provision of activities. The service did not have a dedicated activities coordinator, as part of the care assistant's role was to engage and socialise with people and help them with activities. There was no schedule of planned activities. One member of staff told us activities usually happened in the afternoon and that "We see what people want to do." During our inspection we saw that some staff sat with people and helped them look at books and play board games. Some people took part in a game of bowls. We looked at the activity list for the previous month. There had been a party for Halloween and a firework display on bonfire night. Other activities included armchair exercises, dominoes and a sing along. We were told that some people went on trips. There had been a visit to Chester Zoo during the summer.

Communication between staff working at the home overall was effective. Handover meetings took place at the start of each shift where staff could discuss people's care and support needs. However, we found the handover notes were very brief with minimal information. Daily notes were recorded which described how people presented throughout each shift and how they had spent their time each day. These were more detailed.

From time to time the service provided palliative care and staff were supported by the district nursing service when people reached the end of their life. Where it was appropriate, people had information about their end of life wishes recorded in their care files.

Information about to make a complaint was on display in the entrance hall. The registered manager told us they had not received any recent complaints and minor issues were dealt with as and when they happened to prevent them escalating.

Inadequate

Is the service well-led?

Our findings

At our last inspection in February 2018, we rated 'well led' as 'requires improvement'. We found the service was in breach of three of the regulations of the Health and Social Care Act (2008). These were regulation 15, which relates to the maintenance of the premises, regulation 12, which relates to the safe care and treatment of people and regulation 17, which relates to governance of the service. We issued a requirement notice for the breach of regulation 15 and warning notices for the breach of regulations 12 and 17. The provider submitted an action plan describing the improvements they would make to comply with the regulations. At this inspection, although we found that some improvements had been made, we found further failings at the service and the provider continues to be in breach of regulations 12 and 17 of the Health and Social Care Act (2008). We have also identified a breach of regulation 19 of the health and Social Care Act (2008). There is an ongoing failure in the leadership and governance of the service, identified in this and the last two CQC inspections. This has contributed towards the rating of 'inadequate' in 'well led'.

The management of the service was carried out by three people - the registered manager, the nominated individual/general manager, who was on site four days/nights a week and the administration manager, who worked at the home two days a week and was contactable by phone on other days. The registered manager had registered with the CQC in May 2018, having previously been employed as the home's deputy manager. They are currently enrolled on an NVQ level 5, management and leadership course. Although the registered manager told us they received support on a day to day basis from the nominated individual/general manager and the administration manager, there was no evidence that they had received any formal supervision since starting in the role. The registered manager's last documented supervision was in November 2017, when they were the deputy manager. Supervision is important as it provides people with an opportunity to discuss their progress and any learning and development needs. We found the registered manager did not have any development plan in place to ensure they were working towards the level of knowledge and responsibility required of a registered manager.

Moreover, the registered manager had not been allocated sufficient time to meet their management responsibilities as they spent most of their time providing care and support directly to people who lived at Care at Parkside. Consequently, they had failed to identify the concerns we found during our inspection. These include concerns in recruitment practices, medicines management, infection control, care documentation and the management of risk. These have been described in detail in other sections of this report.

Quality monitoring systems were not effective. At our last two inspections in October 2016 and February 2018, we found the quality of the service was not adequately monitored. On both occasions the service was found to be in breach of regulation 17 of the Health and Social Care Act (2008) – good governance and a warning notice was issued following our last inspection. At this inspection we found there had been no improvement in this area.

The provider's audit file contained a checklist of the different audits required throughout the year. The care documentation audit was scheduled for every six months, although there was no information to show how

many care files should be audited on each occasion. This audit was overdue, as it had last been completed in March 2018. A bedroom room audit was scheduled for completion every six months. There was no indication how many rooms should be checked. We found one room had been checked in June and July 2018. No other rooms had been audited. The audit file contained a copy of the service's 'health and safety in the workplace' audit, dated July 2018. The audit was blank.

Medicines audits had been completed. These included monthly checks and an annual medicines audit carried out by a local pharmacist. However, during our inspection we identified concerns around the management of medicines, including failure to have 'as required' medicines protocols in place. These omissions had not been identified through internal audits. Lack of this documentation was identified at out last inspection. The action plan we received following our last inspection indicated that these protocols would be provided for staff. However, we found this not to be the case.

Accidents and incidents had not been monitored. The audit checklist showed that a monthly audit of accidents/incidents should be carried out. Auditing accidents/incidents helps identity possible trends, such as, a high number of falls occurring at a particular time of day, or in a particular part of the home, and enables a service to take preventative action to keep people safe.

Accidents and incidents had been documented in the incident book, where details about the nature of the incident, the person/people involved and the immediate action taken, such as first aid, were recorded. The accident audit had only been completed on one month, in July 2018, despite a number of accidents being recorded during the year.

The service confidentiality policy states, 'paper records that contain information about an individual should be kept confidential'. Care records were locked in the treatment room when not in use. However, during our inspection we saw other confidential information was not kept secure. We found three prescription requests which contained information including names, addresses, dates of birth and GP addresses were pinned on a notice board in the dining room. A telephone book, containing mobile telephone numbers of all the staff was on a table in the dining room. This meant sensitive information was visible to people who were not authorised to see it. At the time of our inspection flooring contractors were working in the dining room.

We found little attempt had been made to gather people's opinions or feedback about the service. Feedback is important as it helps a service identify areas of good practice and where improvements are needed. This helps to improve the quality of a service. The audit file contained a staff questionnaire which was scheduled to be sent out every six months. We saw one completed questionnaire dated April 2018, which contained positive comments, including, 'Everyone gets on with each other and management are very supportive'. No other questionnaires had been received. The service user questionnaire had not been distributed during 2018. A 'friends and family' questionnaire had been distributed in July 2017. However, this had not been repeated during 2018. The registered manager told us that a considerable number of people living at the home did not have any relatives or other visitors so it was difficult to gather opinions. No feedback had been gathered from healthcare professionals associated with the service.

Although the service referred people to healthcare professionals when specialist advice and help was needed, we found no other attempts had been made to engage or work in partnership with outside agencies, such as the local 'Health and Social Care Partnership Provider Forum'. This group gives support to health and social care providers and offers information about training and changes to local health and social care provision. Working with other agencies helps services share best practise and support each other.

The above concerns demonstrate a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

Communication between the management team and staff was promoted through a fortnightly meeting with senior carers and through a 'WhatsApp' group. The registered manager told us that this was the preferred method of communication for staff, particularly night staff, who had found it difficult to attend meetings in person. No details or information about people who used the service was shared through this group.

From 1 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. At our last inspection in February 2018 we found the inspection rating from the previous CQC inspection was not displayed. We took enforcement action against the provider and issued a fixed penalty notice. At this inspection we found that the inspection rating was displayed in the entrance hall.

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 The provider had failed to ensure the safe management of medicines. The provider had failed to ensure correct infection prevention and control measures were in place. The provider had failed to ensure risks to people's health and safety were managed correctly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure care documentation accurately reflected people's needs. The provider did not have adequate quality monitoring systems in place. The provider had failed to ensure accident/incidents were adequately monitored. The provider had failed to keep confidential information safe. The provider had failed to ensure the registered manager received adequate supervision and managerial support.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The provider had failed to ensure safe recruitment practices were followed.