Priory Park Care Ltd

Priory Park Care Home

Inspection report

Priory Crescent
Penwortham
Preston
Lancashire
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Tel: 01772742248

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service

Priory Park is a care home providing accommodation for up to 40 older people, including people living with dementia. At the time of the inspection there were 26 people living at the home.

People's experience of using this service and what we found
We received information raising concerns about infection prevention and control practices in the home and staff not following the correct use of personal protective equipment (PPE) to prevent the spread of COVID-19. We also received safeguarding concerns regarding the quality of care provided to people on one of the units in the home. We identified improvements were required to support people with their oral hygiene and to ensure they had the right equipment to allow them to get out of their beds.
Prior to the inspection we received information that whistleblowing processes were not being followed. We did not identify any additional concerns in relation to Priory Park Care Home. However, we found that the provider's policy needed further clarity to reflect best practice and to ensure staff were aware of the escalation processes required to share information and ensure people were safe from harm. We have made a recommendation about this.

We inspected the home to see how staff were following national and local COVID-19 guidance including the correct use of PPE and observe how people were cared for. We found people were not adequately protected from the risk of acquiring infections because systems for preventing the spread of infections were not implemented effectively. Staff were not always following the latest guidance on the use of PPE, guidance on the safe admission of people was not robustly followed and infection prevention audits had not been regularly completed.

People were not adequately supported with their oral hygiene. We made a recommendation about oral hygiene practices.

The registered manager was working closely with the local safeguarding team to reflect on the current practice within the service to ensure that lessons were learnt and to make improvements where needed.

Rating at last inspection

The last rating for the service under the previous provider was inadequate, published on 19 December 2019.

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in response to concerns received about infection prevention practices, staff not using PPE in line with national guidance, safeguarding concerns and staff training and induction. A decision was made for us to inspect and examine those risks.

The Care Quality Commission (CQC) have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 the concerns raised about infection prevention and control and oral hygiene and good governance. Please see the safe and well led sections of this full report.

We took enforcement action and issued the provider a warning notice in relation to infection prevention and control. Please see the action we have told the provider to take in relation to good governance at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Priory Park Care Home on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Inspected but not rated	**Inspected but not rated**
Is the service effective? Inspected but not rated.	**Inspected but not rated**
Is the service well-led? Inspected but not rated	**Inspected but not rated**

Priory Park Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had met the requirements of the specific concern we had about infection control, staff training and induction and safeguarding. We will assess all of the key question at the next comprehensive inspection of the service.

Inspection team
This inspection was undertaken by one inspector.

Service and service type
Priory Park 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 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 the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection. We had requested information from the provider prior to the inspection and this information was used as part of the inspection plan.

During the inspection
We spoke with three members of staff including the registered manager, a nurse, the regional manager and

the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included five people's care records, training and induction records and we looked at a variety of records relating to the management of infections and cleanliness. We walked around the premises to observe the environment and care delivery.

After the inspection
We continued to seek clarification from the registered manager, regional manager and the nominated individual to validate evidence found.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. We have not issued a rating for this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to explore the specific concerns we had about Priory Park Care Home. We will assess all of the key question at the next comprehensive inspection of the service.

Preventing and controlling infection;
● People were not adequately protected against the risk of infection. We received concerns staff were not wearing PPE in line with current guidance or following best practice for reducing the risk of cross contamination while providing care to people. During the inspection we observed staff not following the correct use of PPE in care homes. We observed staff wearing face masks below their chins and one staff not using the recommended type of facemasks for those working in care settings. Staff had not received adequate training on the use of PPE.
● While the home was observed to be visibly clean and regular cleaning of high touch areas was carried out, improvements were required to ensure regular infection prevention audits were in place. We noted an audit was in the process of being completed and plans were in place to ensure future audits were carried out regularly in line with the provider's policies.
● The provider and the registered manager had not robustly followed national COVID-19 guidance in relation to the admission of new people into the home and protocols for checking visitors COVID-19 risk status. While there were no cases of Covid-19 at the time of our inspection, the practices in the home exposed people to risk. We referred the home to the local Public Health authority and the provider took immediate action to address some of these concerns.

There was a failure to assess the risks to the health and safety of service users. These were breaches of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Guidance for hand washing, personal protective equipment and infection control were displayed in the service. The provider and the registered manager had proactively supported people to ensure they could continue to maintain contact with their families. They had established a 'visiting pod' which was a protected room where people could see their visitors without physical contact to reduce the risk of COVID-19 infections.

Systems and processes to safeguard people from the risk of abuse; How are risks to people assessed and their safety monitored and managed so they are supported to stay safe and their freedom is respected
● Some improvements were required to ensure systems and processes to prevent the risk of abuse were effective. The provider had a policy on whistleblowing however; they needed to ensure staff read and were

familiar with the requirements and the escalation processes. This included ensuring staff were familiar with the whistleblowing process and their responsibility.

We recommend the provider consider current guidance on promoting effective whistleblowing practices in the home.

● Before the inspection we had received allegations of inappropriate treatment of one service user. The registered manager and the provider took immediate action to report and investigate the concerns that we had received and no evidence of wrong doing was found.
● There was a process for assessing risks, recording accidents and incidents and the registered manager carried out an analysis and discussed ways to minimise them.

Inspected but not rated

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.

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The purpose of this inspection was to explore the specific concerns we had about Priory Park Care Home. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff support: induction, training, skills and experience

- People's needs and choices were assessed and reviewed. People's oral hygiene needs had been assessed and plans were in place, however our observations showed that people had not been supported with their oral hygiene as planned. Some people did not have the aids required to maintain oral care such as toothpaste and toothbrushes in their bedrooms. The provider took action to address this after the inspection.

We recommend the provider consider current guidance on supporting people with their oral hygiene and take action to update their practice accordingly.

- There was a system to provide staff with induction at the beginning of their employment however, some improvements were required to the quality and content to ensure new staff were familiar with health and safety protocols at the home. The provider also needed to ensure staff were trained in the correct use of PPE.
- Before the inspection we had received concerns about people being kept cared for in bed unnecessarily. We reviewed this and found those who were cared for in their beds had a valid reason to do so, however we discussed the need to provided equipment for those who had stayed in bed due to lack of suitable sitting equipment. The registered manager told us they had been in contact with external professional in relation to this.
- The provider had arrangements in place to facilitate the delivery of care and treatment in line with legislation, standards and evidence-based guidance. Staff had access to National Institute for Health and Care Excellence (NICE) guidance, Covid-19 guidance. However, guidance had not been consistently followed including guidance on infection prevention.

Inspected but not rated

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

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The purpose of this inspection was to explore the specific concerns we had about Priory Park Care Home. We will assess all of the key question at the next comprehensive inspection of the service.

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

● Staff and management understood their roles. However, improvements were required to ensure national and local guidance were followed to protect people from avoidable harm as a result of COVID-19. We identified shortfalls in the governance systems especially on the support and guidance offered to staff to ensure they complied with the correct use of PPE, COVID-19 visitor and admissions protocols.
● Whilst the provider had a system for monitoring quality performance and risks. The processes had not been robustly implemented to ensure concerns were rectified timely. For example, the concerns on the use of PPE had already been identified by the provider's representatives before our inspection however, we found the poor practices were still going on at the time of our inspection. This meant lessons had not been learnt to monitor and ensure oversight on staff to change their practices.

There had been a failure to assess, monitor and improve the quality, safety and welfare of service users and others who may be at risk. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the nominated individual took immediate action to start addressing shortfalls we identified. They were committed to improve the care and people's experiences.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to implement effective systems to assess, monitor and improve the quality and safety of the services provided and to respond appropriately and without delay.

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	There was a failure to ensure care and treatment was provided in a safe way for service users because measures for assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated were not robust.

The enforcement action we took:

A warning notice was served on the registered provider under Regulation 12(1)(2)(h)

The provider had not implemented effective systems and processes to prevent and control the spread of infections.