Mrs Letitia Fehintola

Parkfield Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 17 August 2016 and was unannounced. This meant that the provider and staff did not know we would be visiting.

We last inspected the service in May 2014 where we found that they were meeting all the regulations we inspected.

The provider was in day to day charge of the home and as such, there was no requirement for Parkfield Rest Home to have a registered manager in post under their registration with the Commission. The provider told us she was a non-practising nurse and had also completed catering qualifications.

The provider opened the home in 1984. She explained that the home had been up for sale for six years and they were "winding down."

Two people were living at the home at the time of the inspection. They had lived at the home since 2002. Only part of the home was being used due to the small number of people living there.

We spent time looking around the home and found that not all areas were well maintained. In addition, there were shortfalls in infection control procedures. Risk assessments had not been carried out to assess risks relating to the premises and risk assessments for people were limited.

We had concerns with staffing levels since there was only the provider and senior care worker through the week to provide 24 hour care.

People told us that they felt safe. There was a safeguarding policy in place. This had not been updated in line with recent legislation and West Yorkshire's reporting procedures. The provider had not completed safeguarding training and the senior care worker had not undertaken safeguarding adults training since 2006. There were shortfalls with certain aspects of medicines management.

Supervision and appraisals were not documented. The senior care worker had not completed any training since 2006 and there was no evidence that specific training to meet the needs of people who lived at the home had been carried out.

There was no evidence that people had consented to their care and support. During our inspection, it was not always clear whether people's preferences were taken into account.

We checked whether people's nutritional needs were met. The senior care worker informed us that one person required a soft diet because of an incident which had occurred in 2006. There was no evidence that advice had not been sought from a dietitian or speech and language therapist to make sure that the person was receiving a suitable diet. We noted that this person had lost weight in February 2016. There was no

evidence that the person's weight had been rechecked or action taken to reduce the risk of any further weight loss.

It was difficult to find out when people had accessed health care services because this was recorded in copious amounts of daily records. Staff had recorded that it was not necessary for people to see a dentist because they did not have any teeth and did not wear dentures. We considered however, that oral health checks should still be carried out to check there were no irregularities or oral health concerns.

We observed that some interactions between the provider and one individual were not person centred. In addition, the language and terminology used in daily reports did not always promote one person's dignity.

Although staff informed us that people's needs were met in a person centred way; there was limited information in both people's care files to document this care and support. There were no formal arrangements in place for people to have their individual needs regularly assessed and reviewed. The senior care worker told us that this was ongoing.

There was a complaints procedure in place, however, this did not include all relevant information such as up to date contact details about who to contact.

There were no formal systems in place to obtain the views people. The provider said, "They don't like formal systems. We are with them all the time."

There were no systems in place to monitor the quality of the service. The provider informed us that informal undocumented checks were carried out. We identified serious shortfalls with the maintenance of records relating to people, the management of staff and the management of the service. Policies and procedures had not been updated in line with changes in legislation and best practice guidelines.

We had not been notified of certain events and incidents at the service which the provider is legally required to do. The provider was unaware of her responsibilities to do this.

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 take action 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 take action 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.

We found multiple breaches of the Health and Social Care Act 2008. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

Risk assessments had not been carried out to assess risks relating to the premises. Risk assessments for people who lived at the service were limited. Not all areas of the home were well maintained. There were shortfalls in infection control procedures.

The safeguarding procedure had not been updated in line with recent legislation and West Yorkshire's reporting procedures. The provider had not completed safeguarding training.

There were shortfalls with certain aspects of medicines management. We had concerns with staffing levels since there was only the provider and senior care worker through the week to provide 24 hour care.

Is the service effective?

Inadequate

The service was not effective.

Staff had not completed any recent training to ensure that they were up to date with changes in legislation and best practice guidelines. A formal supervision and appraisal system was not in place.

Staff explained that one person required a soft textured diet. There was no evidence however, that advice had been sought from health and social care professionals to ensure a suitable diet was provided for this individual.

There was no evidence that people had consented to their care and support.

Is the service caring?

Requires Improvement

The service was not always caring.

Both people told us that staff were caring.

We observed that some interactions between the provider and one individual were not person centred. In addition, the language and terminology used in daily reports did not always

promote one person's dignity.

There was no evidence that people were involved in their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was limited information in people's care files to evidence that care was provided in a person centred way.

People informed us that their social needs were met.

There was a complaints procedure in place; however this did not include all relevant information such as up to date details about who to contact.

Is the service well-led?

Inadequate

The service was not well led.

There were no systems in place to monitor the quality and safety of the service. In addition, there was no evidence that people and staff were involved in the running of the service.

Policies and procedures had not been updated in line with changes in legislation and best practice guidelines.

We had not been notified of certain events and incidents at the service which the provider is legally required to do. The provider was unaware of her responsibilities to do this.

Parkfield Rest Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection was carried out by one inspector. We visited the service on 17 August 2016. The inspection was unannounced.

We spoke with both people who lived at the home. We spoke with the provider and senior care worker on the day of the inspection and contacted the part time care worker by phone on the Sunday following our inspection.

We examined the care plans of both people and checked the recruitment and training files of both the staff employed. In addition, we checked records relating to the servicing of equipment and premises checks.

We emailed a local authority safeguarding officer and a two commissioning officers. We also contacted the local Healthwatch organisation. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. two commissioning officers responded to our requests for information. Following our inspection we spoke with a community psychiatric nurse, a GP, a reviewing officer from the local authority and an independent advocate.

We checked our information system and noted that the provider had not sent us any notifications since they registered with the Care Quality Commission in 2010.

We did not request a provider information return (PIR) prior to the inspection. A PIR is a form which asks the provider to give some key information about their service; how it is addressing the five questions and what improvements they plan to make.

Inadequate

Is the service safe?

Our findings

Both people told us that they felt safe living at the home and with the staff who supported them. The reviewing officer said, "I didn't have safeguarding concerns. They [people] were approached throughout my visits by [name of staff member]."

There was a safeguarding policy in place. However, this had not been updated in line with recent changes in legislation and West Yorkshire local authority's reporting procedures. We spoke with the senior care worker about what action she would take with regards to reporting allegations of abuse. She said, "We wouldn't follow the old procedures, I would check the council's website [for the number]." The provider had not completed safeguarding adults training and the senior care worker had not undertaken safeguarding adults training since 2006. The provider said there had been no safeguarding issues. She told us, "That would never happen here."

There was a whistleblowing policy in place with contact details that staff could phone if they had any concerns. Whistleblowing is when staff raise a concern about a wrong doing within an organisation. We checked the telephone number and found it was incorrect and the wrong address was recorded. These incorrect details meant there could be a risk that staff may be delayed in reporting any concerns.

We concluded that systems and processes were not fully in place to prevent the risk of abuse.

It was unclear how people's finances were monitored. The provider told us and our own observations confirmed, that they gave one individual her personal allowance each week. The senior care worker said that sometimes they carried out shopping for the person and gave her the receipts. These transactions and expenditures were not recorded. The senior care worker explained that the person managed her own money and said, "We don't touch her money." The senior care worker explained that the local authority managed the other person's finances. She said that they received a small personal allowance each week for the individual. Receipts for any small purchases were not kept. The provider said, "They [local authority] are not bothered about the £4 a week." This meant that there was no evidence to demonstrate that people's finances were being managed appropriately.

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

All providers of health and social care have to comply with the Code of Practice for health and social care on the prevention and control of infections, and related guidance. We found that criterion one of this code, which requires the provider to have systems to manage and monitor the prevention and control of infection was not being fully met. The provider and senior care worker were unaware of this Code of Practice.

The infection control policy was not comprehensive and did not cover all areas outlined in the Code of Practice. In addition, there were no cleaning schedules in place or infection control audits. This meant an effective system was not in place to prevent and minimise the risk of infection.

Staff did not have access to dissolvable laundry bags which help limit the spread of infection. These laundry bags are placed directly into the washing machine and therefore reduce the handling of soiled washing. The senior care worker said, "They [soiled laundry] go down in a bucket and we rinse them out." One person used a commode. There were no guidelines in place to ensure that staff followed best practice to ensure the commode was adequately cleaned. The sluice for the disposal of bodily waste was located in the laundry area. This posed a risk of cross infection.

We noticed that people's bath sponges were discoloured and disintegrating. This was an infection control risk because they could not easily be washed. Liquid hand soap was available in all areas. We saw that fabric towels were available in the toilet and bathroom areas. Fabric towels can be a source of infection since bacteria can be transferred from one person to another. The senior care worker explained that people sometimes put the hand towels down the toilets and this is why they were not readily available. The covering on some of the armchairs in the lounge was split. This was an infection control risk since these areas could not easily be cleaned.

We spent time looking around the premises. One person's wardrobe was in a state of disrepair and the drawers were broken. The provider explained that the person liked their wardrobe this way and did not want a new one. There was no documented information or risk assessment about this issue. There was only one call bell available in people's bedroom. The provider informed us that if the person without the call bell required attention through the night, the other person would use the call bell on her behalf. The shower rail which was situated around the bath was loose. This was a health and safety risk. The provider explained, "We don't have a handy man."

We noted that the special strips on the fire doors had been painted over. These strips help prevent the spread of fire and smoke. The provider said, "Look they have strips, but they have been painted over. No matter how much you tell them [decorator] [they still do it]." This meant there was a risk that the fire doors may not be as effective preventing the spread of fire and smoke.

There was no evidence that an asbestos survey had been carried out. The provider said, "We did have someone round a long time ago and they said we did not have asbestos." It is a legal requirement for providers to undertake an asbestos survey since asbestos containing materials, if found, can pose a health risk.

A Legionella risk assessment had been completed on 28 November 2013. The recommended review date was 28 November 2015. There was no evidence that this had been reviewed. The provider said, "The officer in charge [of the Legionella assessment company] has been along and he is happy." We noted that staff recorded the temperatures of water in the communal bathroom and toilet. We saw that temperatures sometimes exceeded 56 degrees Celsius in the bathroom and toilet wash hand basins. A risk assessment had not been completed to inform staff what action they should take to reduce the risk of injury. The provider explained that there was no hot water in people's bedroom because there was an issue with "the valve." She explained that staff carried water from "another place" within the home to enable people to have a wash. This meant that people did not have immediate access to warm water. In addition, we considered that carrying water around the home was a slip hazard.

The provider informed us that one person enjoyed a hot bath. We noted that bathing water temperature checks were not recorded. The Health and Safety Executive [HSE] guidance, "Managing the risks from hot water and surfaces in health and social care" states "If hot water used for showering or bathing is above 44 °C there is increased risk of serious injury or fatality." This meant there was a risk of harm because there was no evidence that the temperature of people's baths was within safe limits and would not adversely affect

their health.

We checked the management of medicines and examined both people's medicines administration records. We noted that only the medicine name and dosage was included on the MAR; special instructions, allergies and any contraindications were not included on the MARs. In addition, the amount of medicines received into the home was not documented. The senior care worker said, "We know what's come in because we get these [dosette packs] every fortnight." We noted however, that one person had been on a course of antibiotics and it was not clear how many had been received so we could ascertain if these had been administered as prescribed. Topical medicines were not recorded on the MARs. The senior care worker told us that these were recorded in the daily records. We checked daily records and it was not clear when and how often topical medicines had been administered.

The senior care worker had completed medicines training; however, no competency checks were carried out to ensure that they continued to manage medicines safely. The provider stated that she had not completed medicines training since she was a nurse. She told us however, that she was no longer practising as a nurse.

Risk assessments were not in place for certain risks such as pressure ulcers, malnutrition and falls. Risk assessments were limited in one of the care plans we checked and there were no risk assessments in place in the other person's care file we checked. The senior care worker explained that this person had fallen and sustained a fracture. A falls risk assessment was not in place. In addition, the senior care worker told us that the person liked to bathe independently. The provider informed us that this person had previously fainted following a bath. There was no risk assessment in place to document what actions staff should take to ensure the person's safety.

There was a risk policy in place which listed the areas of risks which staff may encounter relating to working practices and the premises. There were copies of blank risk assessments which had not been completed for areas outlined in the risk policy. The provider told us about an incident when a person had nearly fallen down the stairs; no risk assessment was in place to explain how to ensure the person's safety whilst using the stairs. There was a gas fire in the lounge, a risk assessment had not been completed to explain what safety measures were in place.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We checked staffing levels at the service. The provider and senior care worker lived at the care home. The senior care worker had worked at the home since 1993. The provider informed us that she and the senior care worker covered both day and night shifts at the service through the week. She told us, "We both cover the nights" and "I don't have days off…I'm not used to sleeping." We looked at staff rotas; these did not document night time staffing levels. The provider told us, "One sleeps and one is watchful…We don't need to put who works on nights because we work between us."

No dependency or staffing tools were used to calculate staffing levels. There was limited information in people's care plans to demonstrate what support was needed during the day and night. This meant there was no evidence to demonstrate that staffing levels were suitable. In addition we had concerns about the wellbeing of the provider and senior care worker since they were covering the service 24 hours a day.

This meant that there was no evidence to demonstrate that there were sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to ensure service users' needs were met safely

and effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

No new staff had been employed since 2008. It was difficult to find certain information relating to when staff recruitment checks had been carried out for both staff employed. The manager explained that when the senior care worker commenced employment, they were not using application forms and it had been the senior care workers first job, therefore she contacted school for a verbal reference. The other care worker started work prior to recruitment checks being in place because there had been a delay in receiving these. The provider said, "We chased up her references because they hadn't arrived and she already had a CRB from her previous job."

Contingency plans in case of an emergency were not in place. The provider explained that she was on duty and both she and the senior care worker had worked at the service for many years and knew what action to take in the event of a fire, flood or electrical failure.

Inadequate

Is the service effective?

Our findings

We spoke with one person who said, "I think they are very good."

The provider told us that she was a non- practising nurse. She said that she had completed her psychiatric nurse training in 1968, but had come out of nursing in 1978 after she became disillusioned with nursing and the care that was provided. She told us, "I didn't like the way that the patients were looked after."

We checked staff training. We spoke with the senior care worker who explained that they had not undertaken any training for a while because the service was "winding down." She told us, "We don't do very much training." The provider said, "We didn't think we would still be here."

We looked at the training certificates which the provider had completed. These had been undertaken in 1979 and 1980 and included certificates in catering and food hygiene. The provider told us she was unable to locate her nursing certificate. She had not completed medicines training because the senior care worker explained that "she is a nurse." She had also not completed safeguarding training. The provider said, "[Name of senior care worker] has completed this."

We looked at the training that the other care staff had completed. We noted that the senior care worker had last completed any training in 2006 which included, "Adult protection," "Safe handling of medicines" and her "NVQ 4 in Health and Social Care." Prior to this she had completed food hygiene training in 2003 and moving and handling in 2003. There was no evidence that staff had completed training to meet the specific needs of people who lived there. We spoke with the provider about training provision. She told us, "You don't need refresher training; once you are trained you are trained."

This lack of training meant there was a risk that staff were not aware of changes in legislation and best practice guidelines to ensure that people received safe and effective care.

The senior care worker told us that she felt well supported and explained that she worked with the provider and informal support was given continually. She said, "We're always together." The other care worker said, "Yes, I feel well supported and I'm very happy." A formal recorded supervision and appraisal system was not in place. We read the home's policy on training and supervision. This stated, "The homes training and development needs are identified through its formal system of 'staff appraisal' and 'supervision observation.' The performance appraisal is carried out once per year…The supervision observation is carried out on all junior staff bi-monthly i.e. six times per year." This meant that the provider was not following their own policy and undertaking formal supervision and appraisals.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

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.

The provider confirmed that neither she nor the two staff had completed training in the MCA. She told us that no one living at the service was being deprived of their liberty. She explained that they had contacted the local authority DoLS team for an assessment for one individual. She said they were told that the person was not being deprived of their liberty since they did not meet the criteria.

We checked the care files of both people and noted that there was no evidence that people had consented to their care and support. There was no evidence that one person's mental capacity had been assessed because their care plan stated that they had "complex cognitive impairment." We read that they had refused certain medical and care interventions.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent.

We checked how people's dietary needs were met. The senior care worker told us, "We know what their favourite food is, fish and chips and shepherd's pie and pasta and sausages are their favourites." She explained how they met the dietary needs of one person who required a soft diet. She said, "We sometimes put some soup on her sandwich or she sometimes likes a little of her tea [drink] on her sandwich to mix it up."

There were no set menus in place, the senior care worker told us and our own observations confirmed that people's preferences were sought prior to each meal. We heard her ask, "I was going to do baked potato or do you want fish and chips?" One person said that they wanted a baked potato; another said she wanted "pasta with cheese sauce."

Staff were aware of people's likes and dislikes. It was not always clear however whether people's dietary preferences were taken into account. The provider told us that one person did not like red meat. She said, "Everyone needs red meat, they have to eat it" and "I have done catering and nursing and I know what is good for our residents."

The senior care worker explained that one person required a soft diet following an incident which had occurred in 2010. We read that this person had lost weight in February 2016, following a short stay in hospital. There was no evidence however, that her weight had been rechecked. We asked the senior care worker about this issue. She told us, "I believe she was weighed in March [by the district nurse]." She explained that the district nurse however, had not informed them of the person's current weight. The provider said, "If we ever think there is a problem we will weigh them." There was no evidence however, that advice had been sought regarding the weight loss or their swallowing issues. We spoke with the provider about this issue. She told us, "I am an expert in catering." We were concerned however, that the person's need for a soft diet had not been checked by a health and social care professional. In addition, we were unclear about some of the methods to soften the person's diet such as using their cup of tea. There was no information about this in the person's care plan. The provider told us that she would contact the person's GP to request a referral for this individual.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

We checked whether people had access to healthcare services. The reviewing officer told us, "They do seek support from health and social care professional like the psychiatrist" and "I did not have any concerns about the care. She has no pressure sores." The GP told us, "They are quick to inform me if anything is wrong."

We found it difficult to find out when people had accessed health care services because these were recorded in copious daily records. We read that both people did not have any teeth or dentures. Staff had recorded that it was not necessary for them to see a dentist. We read one care plan entry which stated, "She has no need for a dentist at this time. Has no teeth or dentures, she does not like them. If she has a need for dental treatment we can get someone to come to the home." National Institute for Health and Care Excellence [NICE] "Dental recall" guidance states, "The longest interval between oral health reviews for patients aged 18 years and older should be 24 months." NICE defines an oral health review as, "The continuing re-examination of a patient's oral health and risk status." This meant that checks had not been carried out to ascertain whether people had any oral health irregularities.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

Requires Improvement

Is the service caring?

Our findings

Both people told us that staff were caring. One person said, "They are very nice." The other person said "Yes" when we asked her whether staff were caring. We spoke with a reviewing officer who said, "They are very caring." A local authority commissioning officer stated, "It was obvious that staff knew the residents well and were caring in their approach."

The provider and senior care worker spoke positively about ensuring that the needs of people were at the forefront of everything they did. The senior care worker said, "We just make sure that the residents are loved and well looked after." The provider told us, "They are my family," "We are just like a small family" and "The residents are well looked after. The residents are my life. We have residents here who won't settle anywhere else."

We saw that people interacted well with staff. We saw one person kissing the provider's hand. The senior care worker spoke kindly to people and always asked what they wanted to do. We observed that some interactions between the provider and one individual were not always person centred. We heard the provider tell one person, "Sit down and then we will talk," "No talking when you are eating," "[Name of person] tissue for you. You don't need it yet, put it in your sleeve," "No more talking for now" and "Sit properly, you will get neck ache." We spoke with the provider about our observations. She explained that she had to talk with the person in this way because the individual responded to this approach and was at risk of choking if she continued to talk whilst she was eating. She said, "We have to be firm with her, because she is my responsibility and I don't want any harm to come to her. She is at danger of choking." This information about the use of a "firm approach" was not documented in her care plan.

We checked daily records and found that some of the language and terminology used did not promote people's dignity. We read comments such as, "[Name of person] has been a real handful today, she wouldn't stand up for anything," "Overall she was very difficult to deal with all day," "[Name of person's] behaviour was terrible, the only word for it is NIGHTMARE. She will never have a proper bath again, but a strip wash" and "[Name of person] is not too badly behaved today." We spoke with the provider and senior care worker about the language used in daily records. They told us that it was just the way that the entries had been written and they would always promote people's dignity.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect.

There was no evidence in people's care files to demonstrate that they were involved in their care. There were no recent care reviews and no meetings. The provider explained that conversations about people's care were ongoing and reviews were carried out informally.

We spoke with an independent advocate who told us that she had previously been involved with one person who lived at the home. An advocate represents and works with a person who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld.

Requires Improvement

Is the service responsive?

Our findings

Both people said that they would not change anything about living at the service. We asked both people whether staff were responsive to their needs, one person said, "Oh yes." The reviewing officer said that the person she was involved with had said she was happy at the home and did not want to move. The community psychiatric nurse told us, "I go every two weeks. I am quite happy with what they are receiving."

We checked both people's care files which consisted of a file of various documents, many of which contained historical information. The senior care worker informed us that she had updated one person's care documentation. The other person had four different versions of the same care planning documentation. We were unsure which was the most up to date version. There were no formal arrangements in place for people to have their individual needs regularly assessed and reviewed. The senior care worker told us that this was ongoing. This meant there was no evidence to demonstrate that the care being provided was meeting people's needs.

One person was registered blind. There was no documentary evidence to demonstrate that adjustments had been made to ensure the person received the support and equipment they required to promote their independence. They did not have access to a call bell overnight. We spoke with the provider about this issue. She stated that they had sought support from relevant health and social care organisations, however, the person had refused all support and equipment to promote their independence. This information had not been recorded in their care plan.

Although staff informed us that people's needs were met in a person centred way; there was limited information in both people's care files to document this care and support.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care.

We saw that the provider and senior care worker responded to people's physical needs. They supported one person to access the toilet at various times through the day and assisted people at meal times. The provider and senior care worker told us that they did not know of any other care homes which could provide such one to one care.

Both people told us that their social needs were met at the home. We asked one person, "Is there enough going on here to keep you interested?" The person said, "Yes." Staff informed us that one person chose not to go out. We heard staff ask the other person if she wanted to go to Morrison's and whether she wanted to visit the Emmerdale studios. Staff explained that Emmerdale was one of the individual's favourite television programmes. The person informed staff that she did not want to go out on the day of the inspection.

There was no evidence of how people's views were obtained. The provider told us that this was carried out "informally" through continual chats. She told us, "That's how they want it, they don't like anything official."

There was a complaints procedure in place. This did not include any timescales for responding to complaints and it included out of date contact details for CQC. This meant there was a risk that people would not know who to contact if they were unhappy with how their complaint was dealt with or how long it would take for their complaint to be investigated. CQC are not responsible for resolving individual complaints. We use the information we receive when planning our inspections. Both people told us that they had no complaints about living at the home.

Inadequate

Is the service well-led?

Our findings

The provider was in day to day charge of the home and as such, there was no requirement for Parkfield Rest Home to have a registered manager in post under their registration with the Commission.

The provider opened the care home in 1984. She said, "My main aim of opening the home was to make a difference and to love and care for older people." She told us that she was now past retirement age and suffering from ill health and had had put the home up for sale six years ago. She said, "My wanting to finish is well documented" and "I didn't think we would still be here."

There were no formal systems in place to monitor the quality and safety of the service. Formal documented audits and checks were not carried out. The manager told us that she carried out informal checks and explained that they were "winding down" the service. We identified multiple concerns with the service which had not been highlighted by the provider.

We found serious concerns with the maintenance of records relating to people and the management of the service. The reviewing officer told us, "You have to dig and dig and look and look and ask and ask to find anything."

The senior care worker explained that the provider considered that the most important part of the job was ensuring that people received good care and that records were secondary to this. She said, "She [provider] is old school about the paperwork." The lack of documented records meant that we could not evidence that people received safe, effective, responsive and person centred care which was based on best practice guidelines.

There was no documented evidence to demonstrate that people and staff were involved in the running of the service. Meetings for people and staff were not carried out. The provider told us, "They don't like meetings. We have regular chats." The senior care worker said, "We are here together it is ongoing" and "Everything is informal because we are always here 24 hours a day. [Name of provider] is a nurse]." She also told us, "We've got a quality assurance policy but we haven't done it for a long time." We noted that questionnaires had been sent out in December 2014. This meant we were unable to see what changes had been made to improve the service based on staff and people's feedback.

There were policies and procedures in place. These had not been updated in line with changes in changes in legislation and best practice guidelines. They had been last reviewed in 2013. The senior care worker said, "A lot of the policies and procedures are out of date." The provider told us again that this was because they were, "winding down." This meant there was a risk that people may receive care and support which was not based on current best practice guidelines.

There were four versions of the same care planning document for one person. We were not clear which was the most up to date. Risk assessments were not in place for this individual and there were limited risk assessments in the other person's care file we viewed. Risk assessments had not been completed for risks

relating to the premises and certain checks such as the asbestos survey could not be found.

Supervision and appraisals were not documented and the provider was unable to locate her nursing certificate. The senior care worker had not completed any training since 2006 and there was no evidence that specific training to meet the needs of people who lived at the home had been carried out. This meant there was no evidence to demonstrate that staff were being supported to enable them to carry out their role safely and effectively.

The provider and senior care worker were unaware of best practice guidelines such as the National Institute for Health and Care and Excellence's 'Managing medicines in care homes' and the 'Code of practice on the prevention and control of infections and related guidance.' There was no evidence that best practice guidelines or research were followed. This meant there was a risk that people may not receive effective care which is based on best practice guidelines.

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

We spoke with the provider about our findings at the inspection and the shortfalls we identified. She informed us, "We are unique, we do our own things which if we did in front of God he would give us 10 out of 10 for."

The provider and senior care worker were unaware of the need to notify the Commission of certain events and incidents. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of, in line with the requirements of the CQC Registration Regulations 2009. We found that the provider had not notified us of a serious injury which had occurred in November 2015. She told us, "I didn't know we had to do that, we made a report."

This was a breach of regulations 18 of the Care Quality Commission Registration Regulations 2009. Notifications of other incidents.

The findings of this inspection have led the Commission to question the skills and competence of the provider to operate and manage the service. The Commission cannot be assured that the provider is a suitable responsible person to carry on the regulated activity of 'Accommodation for persons who require nursing or personal care.'

This was a breach of Regulation 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirements where the service provider is an individual or partnership. The intention of this regulation is to ensure that people who use services have their needs met because the service is provided by an appropriate person.

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 9 HSCA RA Regulations 2014 Person-centred care The care which was provided was not always appropriate and did not always meet the needs and preferences of people who used the service. Regulation 9 (1)(a)(b)(c)(3)(a)(b)(c).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect. Regulation 10 (1).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was no overall or decision specific consent documented in people's records to evidence that they consented to their care. Regulation 11 (1)(3).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments had not been carried out to assess risks relating to the premises. Risk assessments for people who lived at the service were limited. Not all areas of the home were well maintained. There were shortfalls in infection control procedures. There were shortfalls with the

	management of medicines. Regulation 12 (1)(2)(a)(b)(d)(f)(g)(h).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs There was limited evidence to demonstrate that people received a suitable diet which met their needs and preferences. Regulation 14 (a)(c).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were no formal systems in place to assess, monitor and improve the quality of the service and mitigate the risks. There were serious shortfalls in the maintenance of records relating to people, staff and the management of the service. In addition, there was no evidence that people and staff were involved in the running of the service. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 4 HSCA RA Regulations 2014 Requirements where the service providers is an individual or partnership The provider did not have the skills or competence to operate and manage the service.

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of competent and skilled staff were not deployed to meet people's needs. Staff had not been supported to receive appropriate

support, training, professional development, supervision and appraisal to enable them to carry out the duties. Regulation 18 (1)(2)(a).

The enforcement action we took:

We issued a notice of decision and cancelled the provider's registration.