Park Homes (UK) Limited

Allerton Park Care Centre

Inspection report

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13 July 2023

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Allerton Park Care Centre is a residential care home providing personal and nursing care for up to a maximum of 50 people. The service provides support to people living with dementia and some who have mental health needs. At the time of the inspection there were 46 people living at the service.

People's experience of using this service and what we found
People were not always safe. People were at risk of harm as the provider had not identified, assessed, or mitigated risks. These included risks related to people's health and care needs as well as environmental risks. The environment was tired, not well maintained and appeared unclean. Staff did not always follow safe infection and control practices. Medicines were not managed safely. Some people told us they did not feel safe in the home.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There was a lack of effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level.

Safe recruitment processes were in place and staffing levels were sufficient with effective deployment in the service. Premises and equipment certificates and servicing were in place and in date.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was good (published 18 November 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, management of medicines, consent to care, premises, and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Allerton Park Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out on day 1 by 2 inspectors and An Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day 2 the inspection was carried out by 1 inspector and a medicines inspector.

Service and service type
Allerton Park Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Allerton Park Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced. Inspection activity started on 11 July 2023 and ended on 24 July 2023. We visited the service on 11 and 13 July 2023.

What we did before the inspection
We reviewed information we had received about the service, and 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 (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and 1 relative of people who use the service about their experience of the care provided. We spoke with 10 staff members, including the registered manager, nurse, team leaders, care workers and administration staff. We reviewed 6 people's care records in full, sampled parts of 4 peoples records and reviewed multiple people's medication records.

We looked at 3 staff files in relation to recruitment and staff supervision. We also requested a variety of records relating to the management of the service, including policies and procedures and training documents.

During and after the onsite inspection days we requested further documents, such as audits and governance records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- We reviewed safety check records for people whose care plans stated they needed 2-4 hourly safety checks. This was because they could not call for assistance when cared for in their rooms. We found these safety checks were routinely not being documented as completed, therefore we could not be assured people were kept safe from risks of harm.
- Repositioning records were reviewed for people whose care plans stated they required 2-4 hourly repositioning to avoid pressure area damage. We found large gaps in this documentation, with 1 person on some days only having 1 or 2 repositioning entries documented in a 24-hour period. We were not assured people were in receipt of this care consistently.
- We found daily care records were not always accurate or reflective of the food people had received. For example, on the first day of inspection 4 people were noted to have eaten all their lunch including pudding. However, inspectors had observed these people and saw they had not eaten anything. People were placed nutritionally at risk through inaccurate record keeping.
- We found staff were not intervening in situations where people were distressed and anxious and being placed in situations which increased risks to them. One person was constantly pulling at another person in the home and making them walk around. Staff did not manage this situation well and both people had behaviour support plans in place due to the risk of them becoming physically aggressive. Both these people were at increased risk of falls and harm and the person who was being constantly harassed was visibly distressed and appeared worn out. Their mental health and well being as a result was impacted negatively by poor management of the situation.
- Decorators were in the nursing unit painting the ground floor communal areas. However, this was not well managed and there were multiple risks to people because of the decorating. People were mobilising across material dust sheets on the floor, which was a serious trip hazard for people. Medication was being administered in the same room where the ceiling was being painted. On day 1 there was no risk assessment for the completion of this work, and despite there being a new risk assessment completed by day 2 of the inspection, the risks were still present as the risk assessment had not been effectively implemented or monitored.

We found systems were not robust enough to demonstrate the risks to people's health and safety were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- On both days of the inspection, we found the environment to be run down and in need of repair. This posed a risk to people in the service. There was a refurbishment plan in place, however we still observed 9 wall lights with no covers over the bulbs in corridors, 7 fire doors in need of urgent replacement, one

bedroom had a hole through it where the lock should be, a wooden chock held open an upstairs bathroom window.
● On both days of the inspection fire doors were being propped open with paint tins and plastic boxes. Two of the doors were bedroom doors and we were told this was because the mechanism had broken on the doors meaning they would not stay open independently.
● We observed most people's bedrooms were basic and lacked personalisation. Many of them required updating. One person's toilet was broken and despite them using it regularly this had not been fixed. They said, "I use it and it's been like that for ages, but I say things and they don't listen."
● The overall environment did not smell, look, or feel clean. We identified multiple areas of the home which were malodorous. This included communal bathrooms and bedrooms.
● The environment was not safe for people, and they were not protected from the risk of harm. The attic space was used to house maintenance equipment and decorating tools. On day 1 of our inspection none of the doors were locked despite people having access to this area from the main staircase. Hazardous materials such as paints, flammable liquids, and tools were stored in these rooms, but they were not locked. This put people at risk of harm.

We found the premises were not clean, secure, suitable for purpose or properly maintained. This placed people at risk of harm. This was a breach of Regulation 15(1) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● A new electronic system had been introduced for the management of medicines. However, the change over from the paper-based system to the electronic system was not managed safely. This resulted in medicines not being accounted for as records did not show that medicines had been administered as prescribed.
● Some people missed doses of their medicines, including a thickening powder which is a high-risk medicine, as it is added to fluids to prevent choking and pain relief. This was because medicines had not been ordered in a timely manner.
● Staff giving medicines failed to follow the prescribers' or manufacturers' directions carefully. Some people were prescribed medicines that should be given at specific times or in relation to food. However they were not given at the correct time.
● Some people had swallowing difficulties and were prescribed a thickening agent to add to their drinks. Thickening agents ensure that people's drinks are made to a certain consistency to help the person swallow safely. It was not always possible to see if people's drinks were thickened appropriately as clear and consistent records had not always been made.
● Information was missing to help staff give covert medicines safely (medicines hidden in food or drink). There was no information from a pharmacist about what food and drink each medicine could be mixed with.
● Written guidance was not always in place when people were prescribed medicines to be given 'when required'. When they were in place, they were not sufficiently personalised to ensure the medicines were given properly. Records about why these medicines were given were limited and failed to demonstrate they had been administered appropriately or had been effective.

The provider had failed to ensure there were safe systems for the management and administration of medicines. We found no evidence that people were harmed at the time of the inspection because harm is not always immediate, however, people were placed at increased risk of harm by unsafe management of medicines. This demonstrated a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service was not working within the principles of the MCA.
● Mental capacity assessments and best interest decisions were not always in place for people who had restrictions. We identified 2 people had bed rails and bumpers to prevent them falling out of bed, but no documentation to suggest this was in their best interest and to keep them safe.
● We found 1 person was having their cigarettes restricted with no consent, best interest decision or mental capacity assessment in place for this decision.
● The process for completing and reviewing mental capacity assessments and best interest decisions (BID) was not person centred. We found some mental capacity assessments had not been reviewed since 2021 and when they were completed people, relatives or advocates were not involved in the decision-making process.

The provider had failed to ensure people's care and support was delivered in line with the MCA. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A DoLS tracker was in place which showed when applications had been made and granted and whether the authorisations had any conditions.

Systems and processes to safeguard people from the risk of abuse
● The provider did not have a system in place to record the number of cigarettes 1 person had bought, and subsequently the number of cigarettes that were given to them during the day. This exposed this person to the risk of theft/harm. We raised this on the day of inspection and the registered manager was responsive and prepared a new system and procedure to reduce this potential risk.

● There was a mixed response from people when we asked them if they felt safe. One person told us they were often asked for cigarettes from other people and were subject to verbal abuse if they did not share. This information of concern was passed on to the registered manager who took action to investigate and eliminate this issue.
● Staff told us they had received safeguarding training and knew how to report concerns. They were confident the registered manager would deal with any concerns appropriately.
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Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

● We were not assured that the provider was using PPE effectively and safely. We observed staff failed to change PPE between interactions with people and when providing food and drink.

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. On the first day of inspection the service was not clean or hygienic and there were many areas of the service which were malodorous and appeared uncleaned.

Visiting in care homes
● The provider was facilitating visits for people living at the home to maintain contact with family and friends.

Learning lessons when things go wrong
● Accidents and incidents were well recorded and reviewed regularly by the registered manager who analysed these for trends, patterns, and commonalities.

Staffing and recruitment
● Staffing levels were reviewed regularly with a dependency tool used appropriately to calculate the safe number of staff required per day.
● We found deployment within the service was safe, with a good staff presence in all communal areas.
● People and relatives felt there were enough staff and said if they needed any support staff responded promptly.
● Safe recruitment practices were followed. New staff had Disclosure and Barring Service (DBS) checks prior to employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safe recruitment decisions.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Significant shortfalls were identified at this inspection. The provider's audit systems had failed to identify them. There were breaches in relation to safe care and treatment, medicine management, consent and premises and environment. These issues had not been addressed through the provider's own governance systems.
- Following the first day of inspection, we informed the provider of our concerns, and we made a referral to the local authority safeguarding team. The registered manager responded and sent assurances. However, when we returned on day 2 some issues had been addressed but further issues were identified. We subsequently made further referrals to the local safeguarding team.
- There was a lack of effective leadership and management in the service. Despite quality audit systems being in place these were not effectively implemented to identify or secure improvements. For example, the registered manager completed multiple daily checklists and audits. However, these failed to identify any shortfalls in the service. The registered manager had failed to ensure effective oversight and quality improvement in relation to monitoring of the daily records, repositioning and safety records kept on people.
- Medicine reconciliation from the paper records to the online system was poorly managed by the registered manager, which increased risks to people.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risks. Audits completed had failed to identify or resolve the issues we found on inspection.
- We found no evidence people and their representatives had been involved in care plan reviews, mental capacity assessments or best interest decisions.

People were placed at the risk of harm through the lack of effective governance systems. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had complied with the requirements to notify the Care Quality Commission of various incidents, so we could monitor events happening in the service.
- Staff meetings occurred regularly which involved staff and encouraged suggestions about how the service could be improved.
- We saw evidence surveys and feedback were used to gather comments by people and relatives.

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

● The registered manager understood the requirements of the regulations to make notifications and to comply with duty of candour responsibilities when things had gone wrong.

● The provider had an up-to-date duty of candour policy in place.

● Lessons learnt from accidents and incidents was clearly documented with good analysis for trends and patterns.

Working in partnership with others

● People's records showed involvement from Tissue Viability Nurses, Speech and Language Therapists and GP's.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people's care and support was delivered in line with the MCA. Reg 11 (1)

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 The provider failed to ensure there were safe systems for the management and administration of medicines. Systems were not robust enough to demonstrate the risks to peoples health and safet were effectively managed. Reg 12 (1) (2) (a) (b) (d) (f) (g)

The enforcement action we took:

WN served to provider and also RM for Reg 12 breaches

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment We found the premises were not clean, secure, suitable for purpose or properly maintained. Reg 15(1) (a) (b) (c) (e)

The enforcement action we took:

WN served to both provider and RM for reg 15

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure they had effective governance systems, increasing risk of harm to people. Reg 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

WN served to provider and RM for breach of reg 17.