Park Homes (UK) Limited

Holly Park Care Home

Inspection report

Clayton Lane
Clayton
Bradford
West Yorkshire
BD14 6BB

Tel: 01274884918
Website: www.parkhomesuk.co.uk

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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
Holly Park Care Home is registered to provide accommodation, personal and nursing care for up to 43 people who may be living with dementia or other mental health conditions. There were 26 people using the service at the time of inspection.

People's experience of using this service and what we found
Not enough improvement had been made since the last inspection in May 2019, and the provider continued to be in breach of regulation 9 (person-centred care), regulation 12 (safe care and treatment), regulation 18 (staffing) and regulation 17 (good governance). The service has failed to achieve a good rating and has a history of breaching regulations since being registered with the CQC in January 2011.

Medicines were not always managed safely. Infection control practices were not sufficiently robust to be assured the risk of infection was being mitigated. The provider was not taking appropriate steps to assess risks to people and to keep the premises safe.

People did not have an accurate and complete care record. The care records were not person-centred and did not focus on how the person wanted their care and support needs to be delivered. There was insufficient information to demonstrate the provider was working effectively with other healthcare professionals to ensure care was provided and planned in a timely manner.

The provider's audit systems were not effective as we found the breaches from the previous inspection had not been addressed.

People and staff told us there were enough staff to meet people's needs. Safe recruitment processes were in place to ensure staff were suitable to work with vulnerable people. People told us the manager and staff were approachable. Relatives told us they were kept up to date with management changes and about their family member.

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 requires improvement (published 24 June 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection not enough improvement had been made and the provider was still in breach of regulations. The service had deteriorated to inadequate. This service has been rated either inadequate or requires improvement for the last five consecutive inspections.

Why we inspected
At the last inspection on 29 April 2019 and 1 May 2019, breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve person centred care, safe care and treatment, good governance and staffing.

We undertook this focused inspection to check the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

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

We have identified breaches in relation to medicines management, risk management, safety of premises, infection prevention and control, good governance, person-centred care, lack of support for clinical staff and insufficient partnership working, at this inspection.

You can see what action we have asked the provider to take at the end of this full 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. 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 with the 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.

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 timeframe. 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.

Holly Park Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 by two inspectors, a pharmacist inspector, a specialist nurse advisor 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.

Service and service type
Holly 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 did not have a manager registered with the Care Quality Commission. A registered manager 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.

Inspection activity started on 12 May 2021 and ended on 8 June 2021. We carried out site visits on the 12 and 18 May 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We sought feedback from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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.

During the inspection
We spoke with four people who used the service and four relatives about their experience of the care provided. We spoke with eight members of staff including the manager, clinical lead, operations manager and care staff. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at risk assessments, audits and medication 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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider was not managing medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Medicines were not always managed safely.
- Medicines were not always given by the member of staff who had signed the Medicine Administration Record (MAR), which is not good practice.
- People did not always receive their medicines as prescribed. Some medicines had not been given as they were out of stock, including a pain-relieving patch that was applied a day later than it should have been. Fluid thickener, to thicken a person's drinks to aid safe swallowing, was not recorded when it was used, so we could not be sure this was being managed safely.
- The provider had a process to record where a medicine patch had been applied previously, however staff were not always doing this. Using the same part of the skin again increases the risk of skin irritation and side effects.
- The provider did not have a safe process to check what medicine a person should be taking when they came to the home. Not having an accurate record increases the risk of medicine errors.

We found no evidence that people had been harmed however medicines were not always managed safely. This placed people at risk of harm. This was a continued breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all the issues raised had been addressed.

Assessing risk, safety monitoring and management
- People did not always have risk assessments in place to manage their individual risks. For example, people's nutritional needs had not been assessed and there was no risk assessment in place where one person tried to help care for another person.
- Maintenance checks were carried out, however, where issues were identified there was no evidence to show these had been followed up and resolved. For example, we saw temperature checks had identified low temperatures in some areas of the home which posed a risk of legionella, and another area where the

temperature was recorded at exceeding 47 degrees which could pose a risk of scalding.
● We found a maintenance store cupboard left unlocked on the dementia unit and a maintenance storeroom left unlocked on the residential unit. We could freely access the area and hazards such as a saw, screws, pliers, screwdrivers, chemical lubricant aerosol and paint.
● The fire risk assessment had not been completed by a competent person.

We found no evidence that people had been harmed however risks to people had not been appropriately assessed and the provider was not taking appropriate steps to mitigate risk. Steps were not taken to ensure the premises were safe. This placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all the issues raised had been actioned.

Preventing and controlling infection
● We were not assured that the provider had robust infection and prevention measures in place. For example, on our arrival at the home we had to request our temperatures were taken as part of the provider's infection screening procedures, and we found the thermometer was not working. The area dedicated to visitors and other healthcare professionals to put on and take off their PPE had not been fully risk assessed and did not contain a clinical waste bin.
● Staff had access to PPE and were using this. However, we saw some staff used cloth masks, wore engagement rings and were not bare below the elbow. This increases the risk of passing on infections and does not follow infection and prevention guidance.
● Some areas of the home required a deep clean. The shelves in the dry food store in the kitchen contained ingrained stains. The laundry area had paint flaking from the walls and clothes hangers hung from pipes.

We found no evidence that people had been harmed however infection prevention and control measures were not sufficiently robust. This placed people at risk of harm. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed all the issues raised had been addressed.

● The provider was accessing testing for people using the service and staff.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe living at Holly Park. One person told us, "I feel safe here. Everything seems to run smoothly." Another person said, "I feel safe here. I have made good friends."
● Staff were aware of the signs of abuse and how to report any concerns.
● Safeguarding incidents were recorded, investigated and took into account any learning.

Staffing and recruitment
● People told us there were enough staff. One person said, "Members of staff are normally available and around when we are in the lounge."
● Staffing levels were worked out using a dependency tool. Staff told us there were enough staff to meet people's needs. One staff member said, "The care is brilliant. There is enough staff." Another staff member told us, "There's always someone around."
● Safe recruitment processes were in place to ensure staff were suitable to work with vulnerable people.

Learning lessons when things go wrong

● The manager reviewed safeguarding referrals and accident and incident reports. The manager told us they looked to identify any patterns and trends. There was a section on the audit to document further action required.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

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

At our last inspection we found systems and processes were not effective in managing risks, accurate and complete records were not kept in relation to people who used the service. These failings meant people were at risk of receiving poor care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● Since registration in January 2011 the service has failed to achieve a good rating and has a history of breaching regulations. The lack of consistent leadership is a continued issue since registration of the service.

● People did not have accurate and complete records detailing their care and support needs. For example, one person did not have their own care record and another person had a temporary care plan still in place despite living at Holly Park for over two weeks. Another person's care plan did not contain sufficient detail to manage their complex mental health needs.
● A range of audits were in place to help monitor the quality of the service. However, these were not always effective in identifying issues. This was the fourth inspection where we identified issues with medicines management. The issues identified at the last inspection had not been addressed and improvements had not been made. For example, in relation to care planning.

We found no evidence that people had been harmed however, systems were not effective in managing risks, and accurate and complete records were not in place for each service user. This placed people at risk of harm. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they were in the process of reviewing all care plans. They confirmed all risk assessments had been reviewed and now contained detailed information so risks could be managed effectively

● The provider understood its responsibility around the duty of candour. The manager was aware of their responsibilities of when to notify the CQC and the local authority safeguarding team of any concerns.
● People told us the manager and staff were approachable. One person told us, "I don't feel like I live in an old people's home, they treat me with so much respect."
● Relatives told us they were kept up to date with management changes and about their family member. One relative said, "The management have a good and caring approach and are approachable." Another relative told us, "The management and staff are trying to improve things."

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

At our last inspection the provider had failed to involve people in relation to their care planning and reviews. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People were not involved in their care and support planning. Care records did not show people had been consulted in relation to their preferences. Care records lacked detail in relation to people's choice and preferences and were not written in a person-centred way.
● One person's end of life care plan stated, they did not wish to go into hospital. There was no consideration in relation to their comfort toward the end of their life or funeral choices and arrangements.

We found no evidence that people had been harmed however, there was a lack of person-centred approach to care. This placed people at risk of harm. This was a continued breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed that all care plans were currently being updated by the new manager to ensure they were person-centred.

● The provider had completed staff and service user feedback analysis from a survey completed in October 2020. The response rate was low, and the provider was looking at ways to improve this.
● Regular staff meetings were held to discuss any issues such as PPE, staffing and new staff. There was an opportunity for staff to provide their views.

Continuous learning and improving care
At our last inspection the provider had failed to ensure the staff induction process was followed and clinical staff did not receive opportunities for reflective practice. This did not promote continuous learning and improvement of care. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Although we saw evidence new staff received induction, shadowing and training, clinical supervision and reflective practice had not commenced. We weren't assured clinical staff had the support they required.

We found no evidence that people had been harmed however, clinical staff were not receiving appropriate support. This placed people at risk of harm. This was a continued breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they had produced a clinical supervision form which they would commence using straight away.

Working in partnership with others

At our last inspection we recommended the provider explore opportunities to improve communication with health care professionals who visit the home. Improvements had not been made.

- There was insufficient information to demonstrate other healthcare professionals had been consulted in relation to people's care planning, in particular ongoing medical support and support from other professionals such as podiatry, Speech and Language Therapy (SALT) and dieticians.
- There had been a delay in providing appropriate catheter care due to failing to notify the relevant healthcare professional that a person required a replacement catheter.
- The manager had recently started a monthly meeting with the district nurse team to improve communication.

We found no evidence that people had been harmed however, there was insufficient information to demonstrate the provider was working with others to ensure timely care planning. This placed people at risk of harm. This is a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection and informed us staff had received supervision and training regarding catheter care. They were also going to request training and guidance from the district nursing team.

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 9 HSCA RA Regulations 2014 Person-centred care People were not involved in their care planning and care reviews. People's care records were not personalised and did not reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Clinical staff did not receive clinical support, supervision or reflective practice to enable them to carry out their role effectively.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. The provider was not taking steps to mitigate risk to people or to keep premises safe. We were not assured Infection Prevention and Control measures were robust enough to limit the risk of infection. We were not assured the provider was working effectively with other healthcare professionals to ensure care was provided and planned in a timely manner.

The enforcement action we took:

We served a warning notice.

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 The provider's audits were not effective. They had not addressed the breaches found at the last inspection. Accurate and complete records were not kept in relation to people who used the service.

The enforcement action we took:

We served a warning notice.