Advinia Care Homes Limited

Parklands Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Parklands Court care home provides personal and nursing care for up to 163 people, including older people and people who may live with dementia. At the time of our inspection 100 people were living at the service.

Parklands Court care home is purpose built and consists of six separate, single storey buildings named Collins, Samuel, Harrison, Marlborough, Elmore and Clarendon. Each unit has access to a garden. The Clarendon unit has not been used by the Provider for a number of years and was closed at the time of our inspection.

People's experience of using this service and what we found
Safeguarding concerns were not always recognised and reported to the relevant authority. Where people displayed behaviours that could cause harm to others, risks were not adequately assessed, monitored or reviewed. Some people and most staff felt there wasn't enough staff to meet people's needs, and people had to wait to receive their care, although we did not see this on inspection. Where people received their medicines via a medicinal patch, guidance was not always followed. People and relatives told us they felt safe.

Audits were carried out by the management team and the provider, but they failed to ensure risks were consistently addressed and safeguarding's were recognised and reported. There were inefficient systems to ensure monitoring records were accurate and completed in line with people's assessed needs. People and relatives felt able to raise concerns with the management team and were generally positive about the care they received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 12 June 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
The inspection was prompted in part due to concerns received about the safety and care provided to people in relation to medicines, staffing and increased safeguarding referrals. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service remains the same. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Parklands Court Care Home 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 regulation 13, safeguarding and regulation 17 governance at this inspection.

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 continue to monitor the service. We will work alongside the provider and local authority to monitor progress.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Parklands Court 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 three inspectors, an assistant inspector and a specialist advisor (who was a qualified nurse). One inspector worked off site making phone calls to people's relative and staff.

Service and service type
Parklands Court Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short period notice of the inspection because of the risks associated with COVID-19 and to ensure everyone remained safe during our inspection site visit.

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 clinical commissioning group who commission care from the provider. The provider was not asked to complete a provider information return prior to this inspection. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and seven relatives about their experience of the care provided. We spoke with 18 members of staff including the registered manager, unit managers, nurses, care workers and housekeeping staff.

We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. 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.

Requires Improvement

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 remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse;

- We found three incidents of alleged abuse had not been recognised as a safeguarding concern. Safeguarding procedures were not followed by the provider and the concern was not reported to the local authority safeguarding team for further investigation. This meant the incidents had not been looked into by the appropriate authority and risks had not been reduced. We ensured the provider made the necessary referrals following the inspection.
- Where people demonstrated behaviours that could pose a risk to other people, care plans and risk assessments did not contain sufficient guidance for staff to follow. Staff were not always aware of potential 'triggers' for behaviour or the risks to other people. There was no evaluation of the behaviour to learn lessons and develop the support given. This meant risks to people were not always reduced and we saw repeated safeguarding incidents had occurred.

People had not been protected from the risk of abuse. This constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management

- Risk assessments were not always completed in a timely way when people were admitted to the service. For example, one person had no care plan in place for nine days and key risk assessment for falls and skin damage were not completed until 24 days after their admission. This increased the risk of people receiving unsafe care.
- Monitoring records to support people at risk of skin damage and dehydration were inconsistent. Records did not show people were receiving support in line with their care plans. Although we had no evidence anyone had been harmed, this placed people at the potential of increased risk.
- People and relatives told us they felt safe. A relative told us, "They [the staff] are on the ball and always keep me in the loop and phone if anything is amiss."
- Regular checks were made to environment to ensure people were kept safe, this included checks on fire and safety equipment within the home. Any issues identified were dealt with promptly.

Preventing and controlling infection

- The provider had an infection control policy, and staff received training on COVID-19 and the appropriate usage of PPE. However, some staff did not wear PPE in line with current guidance for preventing the spread of COVID-19 . We saw some staff speaking to people with their face masks under their chin, some staff wearing masks under their noses and staff regularly touching their masks to adjust them.

● People told us they were happy with the cleanliness of the home. One person said, "Everywhere looks nice, clean and fresh." Another told us, "They come in everyday and clean my room."

Staffing and recruitment

● Some people told us there weren't enough staff and they had to wait to receive care. One person said, " There is only one thing when I can't go to the toilet. They are busy and they are understaffed." Another person told us, "Sometimes I am late being changed and have to wait between 20 and 30 minutes."

● Most staff told us at times there were not enough staff to meet people's needs. One staff member said, "Some days sickness is not always covered, repositioning's can be late and people have to wait for the toilet." Another staff member told us, "Some days we are not fully staffed, they try to get somebody but don't always manage."

● Our observations were staff were available to meet people's needs and the provider had a dependency tool to determine the staffing levels required. One to one staffing was in place for the people who required this level of support. The registered manager advised that mainly agency staff were used to meet this need, and on the day of inspection two members of staff were transferred from another unit in the home to offer this support. This meant the care for these people was not always consistent.

Using medicines safely

● At the last inspection we found inconsistency in records when people needed medicine via a skin patch. At this inspection we still had concerns and found patches were not being safely applied in line with the medicines' guidance. This can lead to increased skin irritation for the person and a higher absorption rate which can lead to overdose of the medicine. We discussed this with the registered manager and regional director who updated their systems to address this issue.

● People and relatives told us they were happy with their medicine support.

● Where people received medicines 'as and when required' and covertly (in a disguised way) we saw the appropriate processed had been followed and guidance was in place for staff.

● Staff had training in the administration of medicines and annual competencies were completed.

Learning lessons when things go wrong

● Robust analysis had not occurred following safeguarding incidents, which meant lessons had not been learned to improve the support given and reduce risks.

● Following a medicine audit, concerns had been highlighted on one unit to how people were supported to receive their medicines covertly (in a disguised way). The provider had put into place a tracker which adhered to good practice guidance to make improvements in this area.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems to ensure all safeguarding incidents were recognised and reported were not robust. Staff had received training, but this had not been effective to ensure the provider's safeguarding policy was being implemented. As a result, some potential safeguarding concerns had not been reported to the relevant safeguarding agencies and people had not been fully protected from repeated incidents.
- There were ineffective systems in place to safely support people with distressed behaviours which may pose a risk to others. The risks had not been adequately assessed, monitored and reviewed. As a result, robust action to reduce the risk had not been taken and repeated incidents had occurred.
- There was no effective system to ensure records were accurate and completed in a timely manner. The governance system had identified the concerns we found on inspection in relation to inconsistent recording of monitoring charts and delays in completing and updating risk assessments and care plans. This lack of recording increased the risk of inconsistent care.
- Governance systems had not ensured regular cleaning of touch points and staff were not wearing PPE in line with the providers' risk assessment and government guidance in relation to COVID 19. This increased the risk of unsafe care and transmission of infection

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

- Organisations registered with CQC have a legal obligation to tell us about certain events at the home, so we can take any follow up action needed. Whilst the provider had informed us of some events, we identified allegations of abuse which should have resulted in a notification to CQC, but which had not been completed.

This was a breach of Regulation 18: Notification of other incidents (Registration) Regulations 2009. We are deciding our regulatory response to this breach and will issue a supplementary report once this decision is finalised.

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

● A staff survey had been conducted in October 2019. In this staff raised concerns regarding low staff morale and the approach of the registered manager. There was no further analysis of this information or robust action taken to try and address these concerns.
● There was no effective system to monitor whether people received their care in a timely way. This was a concern raised by most staff and some people , however there was no robust oversight of the call bell system or this concern.
● People and relatives were mostly positive about the care and support and said management were approachable. One person told us, "I like it, a lot the carers are lovely, the environment is great." A relative said, "The staff were amazing supporting [person] when they were ill."
● Relatives told us the home had helped them to stay in regular contact with people during COVID 19 when they were unable to visit. This had enabled them to continue to be involved in the persons care.

Continuous learning and improving care
● The provider had a system to highlight any trends within the service, for example an increase in falls on one particular unit. However, the analysis of this information often focused on the response to the individual. As such opportunities were missed to look at any themes across the home to consider lessons learned more widely and improve care practices.

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
● The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guideline's providers must follow if things go wrong with care and treatment.
● It is a legal requirement that the overall rating from our last inspection is displayed within the service and on the provider's website. We found our rating was displayed in the home and on the website.

Working in partnership with others
● The service worked in partnership with other professionals and agencies, such as community health services and social workers to ensure that people received the care and support they needed. One professional told us, "The service is very responsive and work with me to ensure the service user is happy when moving there."