Mrs Kim Crosskey

Pearson Park Care 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Pearson Park Care Home is a residential care home providing personal care to 15 people, some of whom may be living with dementia and mental health support needs. The service can support up to 24 people. It accommodates people in one adapted building and bedrooms are both single and double occupancy.

People's experience of using this service and what we found
Whilst some improvements had been made since the last inspection, these were not consistently applied across the service. Minor improvements noted at the last inspection had failed to be embedded and maintained, leading to additional breaches in regulations.

The environment and equipment used within the service, continued to be unclean and required maintenance. Medicines continued to not always be administered as prescribed. The provider was not following their own policy in relations to medicines management.

People did not receive person-centred care. Assessments were not used to inform care plans and health needs were not captured in care planning or risk assessed.

People were not always supported to have maximum choice and control of their lives. However, staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We made a recommendation about the Mental Capacity Act and its application.

Additional training had been sought for staff to access. Some staff, but not all had completed this. We made a recommendation about staff training and continuing to monitor this.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 17 June 2022). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations and continues to be rated inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We undertook a focused inspection to review the key questions of safe, effective and well-led only. 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 remains 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 Pearson Park Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to assessing risk, premises and equipment, person-centred care and governance. We made a recommendation about staff training.

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 remains 'Inadequate' and the service is therefore still 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Pearson 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
Two inspectors attended the inspection.

Service and service type
Pearson Park 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.

Notice of inspection
The inspection was unannounced.

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 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 the provider, deputy manager, three care workers and four people who used the service.

We reviewed a range of records. This included four people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess and monitor risk. This placed people at risk of harm. This was a breach of Regulation 12 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.

● People's health needs continued to not be clearly documented, and associated risks were not always considered. This was identified and reported on at the last two inspections.
● People were exposed to a risk of harm in the event of a fire, as important documentation about how to evacuate people had not been updated when people moved bedrooms. Following the inspection, the provider told us they had other documents, available to the fire service, that were accurate.
● Risk assessments in relation to health and safety remained basic and risk assessments for the use of bedrails were not in place.

The failure to assess and monitor risk was a continued breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider failed to have systems in place for the safe administration of medicines. This placed people at risk of harm. This was a breach of Regulation 12 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.

● People's medicines to help manage pain were not being given as prescribed. This was despite one person communicating they were in pain. The provider was not following their own policies in relation to pain management with no recording, monitoring, care plan or risk assessment in place to help support chronic pain management.
● People continued to not always receive their medicines as prescribed. Directions for administering medicines before or with food continued to not always be followed. This was identified at the last

inspection.
● Protocols in place to help guide staff when to administer people's medicines, did not always contain sufficient information.
● The provider did not have body maps in place to guide staff were medicated creams and gels were to be applied.

Failure to have systems in place for the safe administration of medicines was a continued breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to deploy enough staff to meet the needs of the people they care for and support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of Regulation 18.

● Staff were more attentive to people's needs and offered drinks at regular intervals and for people to engage in activities during our inspection. Some people expressed surprise at this, indicating this was not usual practice.
● We continued to observe people waiting for their meals. Some people had almost finished their meals when others on the same table were just receiving theirs. Some people were supported to the dining room for long periods of time before a meal was served.
● Recruitment checks were in place to ensure only suitable persons were employed at the service. Although the provider told us full employment history was checked with applicants, this was not effectively recorded as part of this process.

We recommend the provider continues to review the numbers and deployment of staff to ensure they are meeting people's needs.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises as the service remained unclean in some areas.
● The provider was not following up to date government guidance in relation to testing for COVID-19.
● PPE was available throughout the building for staff to wear.

Visiting in care homes
The provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● There were systems in place to record safeguarding concerns.
● Accident and incidents were recorded.
● There was minimal accidents/incidents or safeguarding concerns recorded. Due to this, there was limited evidence of lessons learnt.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs

At our last inspection the premises were not properly maintained and had not been adapted to meet the needs of people using the service. This was a continued breach of Regulation 15 (Premises and equipment) 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 15.

● Some environmental improvements had been made; however, this standard had not been applied consistently across the building. We still identified areas of the service that required maintenance including flooring, radiators and windows/wooden structures that were mouldy and/or had paint flaking.
● Equipment in place including chairs and floors remained unclean and not fit for use.
● Effort made to use dementia signage was very limited. The poor environment still did not meet the needs of people living with dementia.

The failure to ensure the service and equipment were maintained and clean was a continued breach of Regulation 15, (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet: Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's lunch time experience continued to be uncoordinated. We continued to observe some people waiting a long time to be served their meal when brought into the dining room.
● People were offered additional drinks throughout the day. However, choice in drinks was not provided and when offered biscuits, people were given a biscuit instead of choosing their own. The provider was not encouraging or monitoring fluids for one person who was having recurrent urinary tract infections.
● We observed people continued to be served food without any alternative options being available. Soup was still being served as the main meal on an evening. This was served alongside sandwiches. No choice in soup was provided and the portions were limited. This was not in line with the providers own policy. Following the inspection, the provider told us choices were available to people.

● The service continued to work with health professionals when required.
● Information gathered through assessments carried out prior to people being admitted to the service was not used to create a plan of care.
● The provider continued to lack knowledge and understanding regarding best practice in relation to care planning, risk assessing and assessing capacity.

Systems were either not in place or robust enough to ensure people received person-centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff had received suitable training to meet the needs of the people they care for and support. This was a further breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

● Staff had received some supervision and competency assessments and there was a planner in place to monitor this.
● Staff had completed some additional training to support their understanding of people's specific needs. However, the providers training matrix demonstrated not all staff had completed all courses. Out of 19 staff, only 10 had completed MCA training, 9 had completed diabetes training and only 5 staff had completed falls and fragility training.

We recommend the provider ensures prompt completion of all training and continues to monitor and review the training for staff, based on current needs of people living within the service.

Ensuring consent to care and treatment in line with law and guidance
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. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Although people's capacity to make decision had been considered by the provider, records were often not question specific, and therefore, it was not clear what the provider was considering at the time of the assessment.
● Some people had signed to give consent, when the provider had assessed them as lacking capacity.

We recommend the provider seek advice and guidance from a reputable source, about the MCA and its application in adult social care.

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 inadequate. At this inspection this key question has remained the same. 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; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection systems were either not in place or not robust enough to ensure compliance with regulations. This was a breach of regulation 17 (Good governance) 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 17.

- The provider continued to fail to ensure that they were providing care to a standard that would meet our regulations.
- There continued to be a failure in relation to the building and equipment used, person-centred care, the administration of medicines, records, training, application of the MCA, oversight and governance.
- Where some action had been taken since the last inspection, this standard had not been applied across the service, so sufficient improvement was not made.
- The provider had failed to embed minor improvements that had been identified at the last inspection. For example, improvements had been made at the last inspection in relation to person-centred care and a previous breach of Regulation 9 had been met. This had not been embedded and maintained, and a breach in regulation had been identified at this inspection.
- Audits failed to drive the service forward or embed improvements. There was a lack of understanding in what is needed to meet the Regulations.
- The provider was not following their own policies in relation to medicines management and menus. Records were poor and failed to reflect care being delivered.

Failure to assess, monitor and improve the quality and safety of the service was a continued breach of Regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

- People continued to not receive person-centred care focused on outcomes and promoting choice.
- The service demonstrated they worked with external professionals when required.
- The provider demonstrated an understanding of the duty of candour.