Valley Park Care Centre (Wombwell) Limited

Parklands Care Home

Inspection report

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Wombwell
Barnsley
South Yorkshire
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Parklands care home is registered to provide accommodation with residential and nursing care for up to 52 adults, including those living with dementia and mental health needs. The home is located in Wombwell, near Barnsley and situated within grounds shared with two other care homes owned by the same registered provider.

On 1 and 2 February 2016 the Care Quality Commission carried out an inspection and found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Warning notices were issued for two breaches of regulation and five requirement notices were issued for the further five breaches of regulation. At this inspection we checked that improvements had been made to meet the breaches of regulation. We found sufficient improvements had not been made to meet six of the seven previous breaches and a further breach was identified.

This inspection took place on 2 August 2016 and was unannounced. This meant the people who lived at Parklands and the staff who worked there did not know we were coming.

There was no registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager who was running the home at the last inspection had left, a new manager had commenced employment, but was not present on the day of the inspection. Two of the registered provider's regional service managers were supporting the service.

When we spoke with people who lived at the service they all told us they felt safe and this was supported by their family members.

We found staffing levels were sufficient to meet people's needs, but recruitment of staff still required improvement to include all the relevant information and documents as required by the regulations.

Systems were in place to manage risks to individuals and the environment, but we found sufficient safeguards were not in place as identified in the fire risk assessment to keep people safe in the event of a fire.

Systems and processes were in place for the safe administration of medicines, but we found one medicine being used was beyond its use by date, a concern we had identified to the registered provider at the last inspection, when a warning notice was issued.

There continued to be inconsistency where care plans did not fully reflect whether a person had capacity to make decisions about their care and treatment and consent was not always sought in accordance with the

Mental Capacity Act 2005, a concern we had raised at the previous inspection, when a warning notice was issued.

The majority of people received good support and choices at mealtimes, but this was not consistent for everyone using the service, meaning people's dignity was not always maintained during the mealtime experience.

The premises had been improved to take account of 'best practice' in their design for people living with dementia, but further improvement was required. The registered provider had an action plan in place to address this. There had been improvements with the cleanliness of the home.

Staff received induction, training, supervision and appraisal relevant to their role and responsibilities, but induction training required review to accommodate new guidance, there were some staff who had either not received some training relevant to their role or it needed updating, there was inconsistency in the supervision and appraisal of staff.

People had access to a range of health care professionals to help maintain their health.

People and their relatives spoke positively about staff and said they were kind and caring.

There were systems in place to assess and monitor the quality of service provided, but these had not been effective in achieving compliance with regulations.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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.

Systems and processes were in place for the safe administration of medicines, but improvements were still required around medicines used beyond their use by date, a concern identified at the last inspection.

We found staffing levels were sufficient to meet people's needs, but recruitment of staff continued to require all the relevant information and documents as required by the regulations, a concern identified at the last inspection.

Systems were in place to manage risks to individuals and the environment, but we found sufficient safeguards were not in place as identified in the fire risk assessment to keep people safe in the event of a fire.

There were systems in place to make sure people were protected from abuse and avoidable harm and people expressed no fears or concerns for their safety and this was also reported by their family members.

Improvements had been made with the cleanliness of the home.

Is the service effective?

Inadequate

The service was not effective.

There was a system in place for staff to receive an induction, training, supervision and appraisal relevant to their role, but induction training required review to accommodate new guidance, there were some staff who had either not received some training relevant to their role or it needed updating, there was inconsistency in the supervision and appraisal of staff.

Care plans continued not to fully reflect whether a person had capacity to make decisions about their care and treatment and consent was not always sought in accordance with the Mental Capacity Act 2005, a concern identified at the last inspection.

The majority of people received good support and choices at

mealtimes, but this was not consistent for everyone using the service, meaning people's dignity was not always maintained during the mealtime experience.

Health professionals were contacted in relation to people's health care needs such as doctors and community health teams.

The premises had been improved to take account of 'best practice' in their design for people living with dementia, but further improvement was required.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives spoke positively about staff and said they were kind, caring and respectful.

There were some positive interactions between the people we observed and the staff supporting them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Relatives reported that their family members received appropriate care that was responsive to their needs. They reported they felt involved in decisions made about their relative's care even though care plans and risk assessments did not demonstrate this.

Activities did take place with people, but this required improvement so that all people had the opportunity to engage in activities they enjoyed and were provided with opportunities to access the community unless their needs identified differently.

There was a complaints procedure in place, but improvements were required to check all complaints were acted on and actions taken as a result of a complaint were also addressed.

Is the service well-led?

Inadequate

The service was not well led.

There was inconsistent management of the service.

There were systems in place to assess and monitor the quality of service provided, but these had not been effective in achieving compliance with the regulations.

The service continued to be in breach of five of the six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that were identified at the previous inspection in February 2016 and a new breach had been identified.

Parklands Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 2 August 2016. This was an unannounced inspection which meant no one at the service knew we would be visiting. The inspection team consisted of three adult social care 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.

The registered provider had completed a Provider Information Return (PIR) prior to our inspection in February 2016.

Before our inspection we reviewed the information we held about the service and the registered provider. This included the service's inspection history and current registration status, death notifications and other notifications the registered person is required to tell us about. We also reviewed safeguarding information we had received.

We also contacted the local authority contracts and safeguarding team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with two people who used the service and four people's relatives. We also spoke with two regional service managers, two nurses, a senior care assistant, care assistant, kitchen assistant, the administrator, domestic and handyman.

We observed care to help us understand the experience of people who could not talk with us, spending time in communal areas observing how staff interacted with people and supported them.

We spent time looking at records, which included five people's care records, three staff records and other

records relating to the management of the home, such as training records and quality assurance audits and reports.

Inadequate

Is the service safe?

Our findings

We checked how people's medicines were managed so that they received them safely.

Discussions with nurses on duty identified they were responsible for people's medicines. We saw when they gave people their medicines, the medicines were placed in individual pots and a drink made available. When they went to the person to administer their medicines, we saw they greeted the person and observed them while they took their medicines. Staff were patient and caring when administering medicines and this was done in a courteous and unobtrusive way.

When we checked people's medication administration records (MAR) it showed records were signed after the person had taken their medicines. This meant an accurate record was made of the person taking their medicines.

We saw controlled drugs were in use at the service. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation, which means there are specific instructions about how those drugs are stored and dealt with. This includes the record of the administration of those medicines. We found controlled drugs were dealt with in accordance with the legislation.

We found medicines were securely stored in locked medicine trolleys, which were stored in locked rooms when not in use.

At the last inspection we identified medicine stock that was out of date. On this inspection we also found a set of eye drops that had not been discarded four weeks after they had been opened, despite the date they were opened being recorded to identify this to staff. This meant further improvement was required in regard to the systems and processes in place to ensure medicines used for people are within their expiry guidelines.

We found an inconsistent system in place for using body maps and/or tracking systems for people who had medicines administered via 'patches' applied to their person. This meant there was a risk patches would not be applied on the correct date or applied in the same area.

We also found that information for people who took medicines 'as required' contained generic information about when this might be, which meant there was a risk people might be given the medicine inconsistently. For example, one person was prescribed diazepam for 'agitation'. The protocol did not describe how 'agitation' might be seen for that person.

In July 2016 a notification was received that alleged a person using the service had not received one of their medicines for one week. This investigation is ongoing.

Our findings meant medicines continued not to be managed in a safe way and was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

An inspection action plan was introduced after the last inspection to ensure the regulation for safe care and treatment was met. The action plan stated that all actions would be completed by April 2016. Our findings evidenced the system in place to audit and check this had been completed, together with ongoing robustness to monitor compliance had not been effective in practice.

Our findings meant this was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We checked and found that the systems in place to recruit staff that were fit and proper persons to be employed did not fully meet regulations and therefore there was a risk that people were supported by staff who were not suitable to work at the service.

The recruitment and employment policy/procedure did not include all the information and documents that must be obtained to comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Schedule 3 is a list of information and documents that must be in place for staff that are recruited, including proof of identity, including photograph, Disclosure and Barring Service (DBS) check, satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health or social care, or children or vulnerable adults, where a person has previously been employed in a position working with vulnerable adults or children, satisfactory verification, as far as reasonably practicable, of the reason why the person's employment ended, satisfactory documentation evidence of any qualification relevant to the duties for which the person is employed or appointed to perform, a full employment history, together with a satisfactory written explanation of any gaps in employment and satisfactory information about any physical or mental health conditions which are relevant to a person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment.

We reviewed the recruitment records for three staff members. The records contained a range of information, but each record did not include all the information and documents specified in Schedule 3.

This demonstrated a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An inspection action plan was introduced after the last inspection to ensure the regulation for fit and proper persons employed would be met. The action plan stated that all actions would be complete by April 2016. Our findings evidence the system in place to audit and check this had been completed, together with ongoing robustness was not effective in practice.

This demonstrated a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked that sufficient numbers of suitable staff were on duty to keep people safe and meet their needs.

The regional service manager provided the dependency/staffing tool that was being piloted by the service. The resource record identified two nursing staff were required 8:00am to 2:00pm and one nurse from 2:00pm until 8:00am, six care staff between the hours of 8:00am and 8:00pm and five care staff between 8:00pm and 8:00am. Two people had been identified to us as requiring one to one support by staff between the hours of 8:00am and 8:00pm and one person as requiring 24 hour one to one support from a member of staff.

We checked the staff rosters for the three weeks prior the inspection to confirm the numbers of staff

corresponded to the resource record. 12 out of 21 days less than the identified number of nurses were on duty during the 8:00am – 2:00pm shift and four out of 21 shifts at night did not have the identified number of care staff on duty.

In addition to nursing and care staff the home employed an administrator and ancillary staff that included domestics, maintenance staff and cooks.

Our discussions with people's family members did not raise any concerns about the numbers of staff available. All the staff spoken with thought there were enough staff provided to meet and support people with their needs. From our observations during the inspection we noted staff were visible around the home. We saw staff did not rush people whilst supporting them.

We checked systems in place for how the service managed risks to individuals and the service to ensure people and others were safe.

Individual risk assessments were in place for people who used the service in relation to their support and care. For example, if a person's mobility had changed and they were at a higher risk of falling. These were reviewed and amended in response to their needs, although there had been gaps in some reviews of risk assessments we looked at.

Systems were in place to monitor the safety of the building and the equipment in use within the home such as bed rails and profile beds, staff call systems, window restrictors, water quality, water temperatures, legionella, fire and electrics.

We found that each person who used the service had a personal emergency evacuation plan (PEEP).

The home had a fire risk assessment in place which had been recently reviewed and included an emergency evacuation plan. This had not been signed by staff to evidence they were aware of the plan to follow in the event of an emergency. We looked at the training matrix provided and found 21 of the 57 staff had not received fire training. We also found that of the thirteen night staff, only three of those staff were identified as having up to date fire training. From May 2016 no fire drills had been held, other than when the fire alarm had activated, none of which were during the night. During that time four of the activations had been started by a person living at the home. At the last inspection we had spoken with the manager about this and the need to record information in the records about any corrective action required by staff following a fire drill to minimise the risk of staff becoming complacent should the alarm continue to be activated on a regular basis. The fire risk assessment dated 14 July 2015 identified no regular evacuation training or drills as a significant risk.

This meant effective safeguards were not in place as identified in the fire risk assessment to keep people safe in the event of a fire and is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition, that an effective system was not in operation to monitor risks associated with the running of the service and therefore a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked that people were protected from bullying, harassment, avoidable harm and abuse that may breach their human rights.

People we spoke with told us that they felt safe and their relatives supported this. Comments included, "Yes it's very safe. I am ok here. It's nice", "We definitely feel he's safe and we trust the staff. The only problem we've had is from other resident's relatives who don't seem to understand why [relative] causes a problem sometimes" and "They look after dad well here. Now mum's ill we can't always get in, but we feel safe leaving him".

Staff confirmed they had been provided with safeguarding vulnerable adults training so they had an understanding of their responsibilities to protect people from harm. They could describe the different types of abuse and were clear of the actions they should take if they suspected abuse or if an allegation was made so that correct procedures were followed to uphold people's safety. Staff knew about whistle blowing procedures. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. This meant staff were aware of how to report any unsafe practice. Staff said they would always report any concerns to the qualified nurse, home manager or registered provider.

The provider had sent CQC of ten notifications in relation to allegations of abuse since the last inspection. The receipt of notifications demonstrated systems and processes in place to report allegations of abuse were followed. Actions taken as a result of the allegations demonstrated the service investigated incidents when they became aware of them.

We checked and found that in the main the home was much cleaner, with a system in place to manage offensive and unpleasant odours downstairs, where all but one person were living.

We spoke with the housekeeper who explained the systems and processes in place for the cleaning of the home, which met prevention and control of infection guidelines.

We viewed the laundry area and no risks were identified with the prevention and control of infection.

Linen was stored in a way that did not pose a risk to the prevention and control of infection.

Inadequate

Is the service effective?

Our findings

We checked that people consented to care and treatment in line with legislation 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. The application procedures for this in care homes and hospitals are 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 were being met.

At the last inspection we had confirmed the service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

We found that DoLS applications had been made where it was considered that the person did not have capacity to consent to reside at the service, some of which had been authorised.

However, the service continued to be unable to demonstrate that consent was sought in accordance with the MCA where people lacked capacity to give consent, including for one person we had identified in the warning notice at the last inspection.

We had received a notification about a safeguarding incident, the outcome of which had resulted in an alarm being placed on a person's door to alert staff when it was opened to minimise further risk of potential harm. When we checked this person's file there was no evidence a MCA had been carried out to assess their mental capacity to make that decision and a record that where they lacked capacity evidence that a best interest meeting had been held and a record of that decision had been made and that it was the least restrictive option. The current situation was that the risk presented was no longer applicable, but the restriction was still in place, despite reviews of risks taking place. The regional service manager said that the family had insisted on the alarm being in place.

Staff we spoke with had a basic knowledge of the principles of the MCA and DoLS. Staff confirmed that they had been provided with training in MCA and DoLS and could describe what these meant in practice.

Our findings showed that care and treatment was not always provided with consent of the person, and in accordance with the MCA 2005, where a person lacked capacity and was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The service's action plan identified that the action taken to meet the regulation had been met in April 2016

to meet the timescale in the warning notice. This meant an effective system was not in operation to ensure compliance with regulations and the registered provider's own action plan and therefore a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether people were supported to have sufficient to eat and drink and maintain a balanced diet.

To do this we viewed people's nutritional assessments and associated care plans, and observed the breakfast and lunch time meal. We also spoke with people and their relatives about the mealtime experience.

People's nutritional needs had been assessed during the care and support planning process and people's needs in relation to nutrition identified.

We spoke with a kitchen assistant who was aware of people's food preferences and special diets so that these could be respected. There was a four week menu plan.

The menu board in the dining room described the meal for the day, including in pictorial format.

Our observation of the breakfast and lunchtime services found people were better supported than on the last inspection, but further improvements were needed as one person had a poor mealtime experience. Their meal had been placed on an occasional table in front of the lounge chair arm they were sat at, which meant they were unable to reach the meal easily, which caused their food to fall from the fork onto their trousers, which meant they then ate the food from their trousers. This continued for 40 minutes, during which time they dropped their fork and tried to eat with their knife. A nurse was administering medicine from a medicine trolley that was placed in front of the person, which obstructed most staff from observing the person. A member of staff did eventually attend the person and assisted them to cut up their meal and bring a clean fork.

Another person was shouting and quite agitated about people walking past the table they were sat at. Staff explained the person had recently moved from upstairs and the change in environment had upset them. Moving the person to eat their meal in a quieter area might have provided a better environment for the person.

We saw some people ate in the dining room and others in the lounge area.

We saw two staff members sitting beside people who needed assistance to eat. The staff members sat level with each person, stayed with them, explained what was happening and supported them at their own pace.

The mealtime experience was also interrupted by a window cleaner cleaning windows and domestic taking their trolley through the lounge area (next to the dining area) where some people were being supported to eat.. Distracting people who have dementia means their attention can be diverted from the task they are doing, which means when there are interruptions at mealtimes, there is a risk they will be distracted from eating.

Our findings demonstrated that further improvement was required so that everyone was treated with dignity and respect at all times. This meant there was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked that staff received training, supervision and appraisal so that they had the knowledge and skills to provide effective care to people.

Relatives we spoke with did not express any concerns about the competence of staff. One relative said, "I am very relieved that staff are able to manage the residents. They are trained to deal with [relative's] behaviour here. I feel comfortable leaving them".

We looked at one member of staff's induction to prepare them for their role. The induction was carried out over three days and included health and safety, infection control, Control of Substances Hazardous to Health, food hygiene, safeguarding, dementia awareness, moving and handling, equality and diversity and basic life support. The induction had not included the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The registered service manager told us this was something the service were implementing.

Staff told us the recent training was 'good' and said the training provided them with the skills they needed to do their job.

The manager provided a recent training matrix, the record by which training was monitored so that training updates could be delivered to maintain staff skills. The breadth of training included, dignity, fire, first aid, health and safety, food hygiene, infection control, moving and handling, safeguarding, care planning, reporting, dementia awareness, MCA, medicines, moving people, nutrition and person centred care. We found there were staff who had either not received training or up to date training in some areas, including, dignity, fire, first aid, health and safety and medicines.

The action plan to meet the breach of Regulation 10 for dignity and respect included ensuring staff had received training in the subject and that this should be completed by April 2016.

The regional service manager provided the supervision matrix to verify the supervision that staff had received. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. We found there was inconsistency in the numbers of supervision staff had received since the last inspection, but most had received two supervisions. However, we found a member of staff who had not been included in the matrix and their files did not included supervisions they had received.

When we spoke with staff most of them told us they received supervision, but were given opportunities to discuss any issues or share information, if they needed to.

Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. These are important in order to ensure staff are adequately supported in their roles.

The staff training and development policy stated all staff members should have their performance appraised at least annually. The regional service manager originally said that supervisions took account of appraisals, but then provided an appraisal matrix for 2015. This showed 13 out of 44 staff had not received an appraisal in that timescale.

The above demonstrates a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing.

We checked how people's individual needs were met by the adaptation, design and decoration of the service.

People, relatives and staff we spoke with all commented positively on the refurbishment that had commenced at the service. One relative commented about the spaciousness of the communal area saying, "It's spacious in here which is what [relative] likes - they can wander around".

Improvements had included making the external grounds safe and secure so people could have access to the gardens.

We saw the refurbishment had improved the aesthetics of the environment, but further work is needed to continue improvements, including that the premise took account of 'best practice' in their design for people living with dementia, by having clear signage around the building for people.

We checked some bedrooms, most of them where refurbishment had taken place. However, we checked one room where a person resided and there was an underlying smell of urine in the room and the duvet and pillows were lumpy, a concern we had raised at the last inspection.

We checked that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support.

Relatives were positive about the effectiveness of the care their family member received. They told us they were kept up to date about changes to their family member's health.

In people's care records we saw entries of involvement from other professionals with people's care, including doctors, specialist nurses, opticians and dentists. This showed that people were supported with their health needs where required.

Requires Improvement

Is the service caring?

Our findings

People we spoke with said they were happy living at Parklands care home and thought staff were caring and respectful. This was supported by their family members.

We saw the service had received positive feedback from a health professional about the care they provided at the end of a person's life. It stated, 'excellent care of a patient in the later stages of their life. [Staff member] demonstrated an outstanding level of care for both their patient and their relatives. Clinically they were able to identify problems and were instrumental in ensuring prompt reviews and ensuring safe care for the patient. This was a particularly difficult case and [staff member] was a great hep with organising multi-disciplinary team meetings, communicating with relatives and professionals alike. Palliative care can be difficult and especially for those caring for the patients as they have developed a bond with patients. It was clear [staff member] cared for their patient and vice versa. This is just to show appreciation of their hard work'.

Our observations showed there were some positive interactions between people and the staff supporting them. There was some very professional and good care. In general relationships looked easy and friendly. For example, we saw one member of staff helping a person with their breakfast. They explained what the food was on the spoon, asked them if it was ok and wiped their mouth after every spoonful.

We saw some people had a lie in, which told us rising time were people's choice and therefore person centred.

One member of staff told us they were worried about a person's health, which they checked and then reported to the nurse.

We saw that in the main, people had clean and manicured nails, looked tidy and clean, showing they had received good support with personal care and grooming.

We saw staff knocking on bedroom doors before they entered, demonstrating respect for people.

We saw staff use touch and sit at the side of people or bend down to crouch at the same level whilst supporting and talking to them. Most people appeared content and we consistently saw staff were patient with people and repeated reassurance. Staff did not rush people in the conversation they were participating in.

We did not see or hear staff discussing any personal information openly or compromising people's confidentiality.

Staff we spoke with were able to describe how they maintained people's dignity and respect and gave examples of how they would implement this. This included practice such as ensuring personal care was provided discreetly and maintaining confidentiality.

We saw that information was provided to people who used the service about how they could access advocacy services if they wished. Leaflets on advocacy services were on display in the reception area. An advocate is a person who would support and speak up for a person who doesn't have any family members or friends that can act on their behalf.

Since the last inspection locking devices on the doors of the toilets in the corridor opposite the lounges on the ground floor had been fitted. We feedback to the regional service manager that one was not working and the other was very stiff to use, which means people and staff would have difficulty using them, thus ensuring people's privacy.

Requires Improvement

Is the service responsive?

Our findings

We checked that people received personalised care that was responsive to their needs.

When we spoke with the relatives of people they told us staff were responsive to their family member's care needs. Comments included, "We had a horrible time with dad at home. He's much better now he's here. He has even put weight on. They [staff] are good with him and they [staff] are brilliant with mum when we visit", "We feel better knowing he's here. The staff know more about him than we do now. They even play football with him" and "Every single time there's an incident no matter how small they phone me. There was an incident last night and they rang me".

One relative told us they had not been involved in producing a care plan for the person or any reviews because 'they were happy to leave them to it'. They said there had been relative's meeting but they hadn't attended. We found there had been one resident/relative meeting since the last inspection, but no-one had attended.

We looked at five people's care plans. Assessments and care plans were in place, but there was inconsistency in them to demonstrate people or their family members had been asked for their opinions and had been involved in the assessment and care planning process to make sure they could share what was important to them. However, when we spoke with relatives they told us they felt involved in decisions made about the care their relatives received. We saw that care plans had been reviewed, but there had been gaps in these being reviewed monthly.

An activities worker had recently been employed by the service, but was not working during the inspection.

We spoke with one member of staff who was a member of care staff, but working in the capacity of activity worker that day. The member of staff brought a person some knitting, but just sat and watched them unsuccessfully trying to knit, with very little interaction apart from kindly eye contact.

Staff could not recall any recent day trips. One member of staff said people used to go for a walk to the High Street, but it doesn't happen any more. They said people do use the garden area.

We saw the television was used for the benefit of people using the service. People and staff sat watching a film together and then a very old episode of Coronation Street, which a few people enjoyed.

We saw there was minimal equipment available for people to use, to engage them in activities.

Since the last inspection a room had been fitted out as a hairdressers/barber shop and was used once a week when the hairdresser visited.

We checked how the service listened and learnt from people's experiences, concerns and complaints.

When we spoke with people and their relatives none had concerns they wished to raise, but would be confident in making their complaints known.

We saw a complaints policy/procedure was in the reception area for visitors to identify how they might make a complaint. We saw the information was out of date, as it contained details of a manager who had left the service prior to our last inspection. The regional service manager confirmed they'd amended this subsequent to the inspection.

We found there was a record of complaints and that there was evidence of investigation, action and response to complainants. However, we found two complaints about the same person, raising similar concerns. For the first complaint no response was made. This had been identified via the services auditing processes. The second complaint had been responded to, but the response to the complainant, asked if the first complaint they had made had been dealt with.

We checked the outcome in a response to another concern that had been responded, identifying to the complainant that the staff member would face disciplinary. We found the staff member was undergoing disciplinary procedures, but the concern was not referenced to within it.

This meant the systems and process in place to monitor complaints was not always effective in practice, both in terms of the response to the complainant and sharing any learning, which demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good governance.

Inadequate

Is the service well-led?

Our findings

We checked that the service demonstrated good management and leadership, and delivered high quality care, by promoting a positive culture that is person-centred, open, inclusive and empowering.

The registered provider had displayed their most recent rating on the premises and on their website in accordance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the current registration certificate was not displayed at the premise. The regional service manager confirmed they had done this subsequent to the inspection.

The service continued not to have a registered manager. The manager in place had the last inspection had left. A new manager had commenced, but was not working on the day of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

General observation of the management of Parklands care home was that the regional service managers were visible and involved with the day to day running of the home. The atmosphere was friendly.

People did not make any comments about the management and leadership of the service. One relative said, "There have been a lot of changes in management. I'm not really sure who's in charge now".

Staff's views of management identified they were visible in the home and were supportive.

There was a schedule in place to check the quality of the service provided including monthly audits for medicines, care plans, daily charts, finances and monitoring and bi-monthly audits of the environment, staff files and kitchen.

The service formulated actions required from each of the audits onto one action plan to monitor ongoing improvements and that the action had been taken. Alongside this was a separate action plan to deal with areas of concern raised during the last inspection. We saw that the action plan had identified improvements required, including those where the timescale had passed in the 'CQC action plan'.

Our findings from this inspection identified the governance systems in place to evaluate and improve practice in regard to past breaches of regulation had not consistently been effective and the service remained in breach of regulations in regard to dignity and respect, need for consent, safe care and treatment, premises and equipment, good governance and fit and proper persons employed. A further breach in regard to staffing had been identified.

Our findings demonstrated the service was not meeting the requirements of the regulations in regard to good governance and was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us staff meetings took place, which meant staff were provided with an opportunity to share their views about the care provided. We found that at staff meetings, staff discussions included topics such as infection control, moving people, meal times, care plans, training, the roles of staff and laundry. However, the records of meetings provided identified only one meeting had been held with all levels of staff since the last inspection.

We found a resident and relative meeting had been held to provide people with an opportunity to feedback their opinions of the quality of service provided since the last inspection, but no-one had attended.

The home had policies and procedures in place which covered all aspects of the service. The policies and procedures had been updated and reviewed as necessary, for example, when legislation changed. This had not always been effective in ensuring regulations were reflected in the services policies, for example, the recruitment and selection policy/procedure and that procedures identified within policies were carried out, for example, staff training and development policy.

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 10 HSCA RA Regulations 2014 Dignity and respect Service users were not always treated with dignity and respect

The enforcement action we took:

NOP to vary the provider's registration to remove the location Parklands Care Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person

The enforcement action we took:

NOP to vary the provider's registration to remove the location Parklands Care Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for service users

The enforcement action we took:

NOP to vary the provider's registration to remove the location Parklands Care Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were either not established or operating effectively to ensure compliance with the regulations

The enforcement action we took:

NOP to vary the provider's registration to remove the location Parklands Care Home

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed All information as specified in Schedule 3 was not available in relation to each such person employed and such other information as is required under any enactment to be kept by the registered person in relation to such persons employed

The enforcement action we took:

NOP to vary the provider's registration to remove the location Parklands Care Home

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Persons employed by the service provider in the provision of the regulated activity had not always received such appropriate support, training, professional development, supervision and appraisal, as is necessary to enable them to carry out the duties they are employed to perform

The enforcement action we took:

NOP to vary the provider's registration to remove the location Parklands Care Home