Parkcare Homes (No.2) Limited

Blyton Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Blyton Court is a nursing home, providing accommodation, personal and nursing care to 14 people at the time of the inspection. The service can support up to 18 people. The service supports people with a learning and/or physical disability and autistic people. The service also supports people living with an acquired brain injury.

People's experience of using this service and what we found
Right Support
• Improvements were needed to activity planning to ensure that people could pursue their interests in a more meaningful way.
• People did not always receive medicines safely.
• Monitoring and reviewing support plans, risks, health and wellbeing was not consistent.

Right Care
• Staff were trained and understood how to protect people from poor care and abuse.
• There was information on display about safeguarding and whistleblowing.

Right Culture
• The provider did not obtain feedback from people and stakeholders and there was no evidence on how the service promoted improvement or acted on people's views.
• Relatives felt confident to approach the provider with any concerns they had and were positive about the communication 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 good (published 23 January 2020).

Why we inspected
We received information of concern about staffing levels at this service. This was initially a targeted inspection looking at the infection prevention and control measures the provider has in place. We also asked the provider about any staffing pressures the service was experiencing and whether this impacted the service. We inspected and found concerns with the provider's management and oversight of the service. As a

result, we widened the scope of the inspection and undertook a focused inspection looking at the key questions safe, responsive and well led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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. This included checking the provider was meeting COVID-19 vaccination requirements.

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

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Blyton Court 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 have identified breaches in relation to safety, good governance, leadership and management of the service 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 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.

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 always safe	**Requires Improvement**
Is the service responsive? The service was not always responsive	**Requires Improvement**
Is the service well-led? The service was not always well-led	**Requires Improvement**

Blyton Court

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 carried out the inspection.

Service and service type
Blyton Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Blyton Court is a care home with nursing care. 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. This means that only the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We carried out an unannounced inspection on 3 February 2022 to seek assurance on infection prevention and control measures in place and to understand any staffing pressures that impacted the service. However, due to our concerns during our visit, we widened the scope of the inspection. We gave the service 48 hours' notice of the second day of inspection. Blyton Court is a small service and we needed to be sure that the provider would be in the office to support the inspection.

What we did before inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we had received about the service since the last inspection. This information helps support our inspections. We used this information to plan our inspection.

During the inspection
We spoke with three people who use the service. People using the service had a range of communication needs ranging from those who could communicate verbally and those who communicated using signs, body language and objects of reference. We observed people and their interactions with staff and each other. We spoke to five relatives about their experience of the care provided.

We spoke with six staff members, including a nurse, activities coordinator, support workers, maintenance staff and operations director.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. We reviewed various records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at training data and quality assurance records.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. 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.

Assessing risk, safety monitoring and management
•Systems to identify risks relating to emergency evacuations were not effective. We saw one fire door was locked and had not been risk assessed to ensure people could evacuate effectively in the event of an emergency. We reviewed a recent evacuation record that showed environmental concerns and that two people had refused to evacuate. However, we found no evidence follow up action to promote safety had taken place.
• The provider did not consistently update risk assessments. For example, we found that malnutrition universal screening tools (MUST) and oral hygiene monitoring documentation were not up to date. A support plan we reviewed said the person needed their health monitoring by a nurse; documentation around this was also not up to date. This meant that deterioration to a person's health, well-being or change in need may not be reflected in support plans and placed them at risk of inconsistent, unsafe support.
• Systems around ensuring the safety of first aid items were not effective. For example, for the two eyewash stations on the first floor, we found that both the eyewash solutions and dressings had surpassed the manufacturer's expiry dates.

Using medicines safely
• People were not always given medicines in line with their support plans. For example, a support plan we reviewed said the person needed to be informed that they were having medicines; however, we observed staff giving people medicines in food and drink without informing them.
• The provider did not always ensure medicines administered covertly were managed safely. For example, we observed staff giving another person medicines with food and there was no information in support plans that the GP or pharmacist was involved in these decisions and medicines could be given safely in food.

Preventing and controlling infection
• Improvements needed to be made to the environment. For example; specialist seating in the lounge had become ripped and areas of the service needed refurbishment and repairs, such as bathrooms. This meant these areas couldn't be cleaned effectively.
• The provider was accessing testing for people and staff. However, systems around lateral flow testing for COVID-19 were not robust. There was a lack of management oversight in ensuring staff had completed lateral flow testing.

Systems and processes were not effective in ensuring people received safe care and treatment. This placed people at risk of receiving unsafe care. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider's quality assurance team gave us assurances that they would be looking at ways to improve issues raised regarding safe medicines practices. There was action taken by the maintenance team to improve the environment to ensure hygienic cleaning could be achieved. The senior management and quality assurance team reflected that there was more that needed to be done to improve systems and processes and the environment.

• There were effective systems to manage laundry and reduce the risk of cross-contamination. For example, the laundry room had two doors, which meant that dirty laundry could come in one way and clean laundry could exit through the other door.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider's infection prevention and control policy was up to date.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

• We have signposted the provider to resources to develop their approach.

Staffing and recruitment
• There was not always enough of the right staff to meet people's health needs. We reviewed notifications and records, which reflected that nurse cover was sometimes unavailable for the service due to the provider's difficulty in recruiting nurses. However, the provider mitigated risks by ensuring staff on duty knew people's needs well and additional management support was on hand. Furthermore, they communicated this with relevant external professionals.
• The provider had recruited staff safely. We reviewed two staff files; the provider had checked right to work documentation and references. Before starting work, potential staff had disclosure and barring service (DBS) checks. These checks provide details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• New staff members received induction and were documented in staff files.

Systems and processes to safeguard people from the risk of abuse
• People were protected from risk of abuse. Relatives we talked with felt their relations were safe; they told us they could contact the provider if they had concerns.
• The provider had reported safeguarding concerns by making referrals to the local authority and the Care Quality Commission. Where appropriate these concerns were investigated by the provider.
• There were systems in place to promote whistle-blowing. The provider displayed information for staff on using the company's whistle-blowing service and details on contacting external agencies such as the local authority and Care Quality Commission.

Learning lessons when things go wrong
• The service learnt from incidents and accidents. The provider used an electronic system to ensure they had management oversight to address any actions. However, not all staff could use these systems to report incidents. Only senior staff members could record incidents on this system. We raised this to the provider, who said they would look into paper-based copies being available to all staff.
• Incident and accident debriefing took place. Staff told us that they had a "Huddle" after an incident and reflected on lessons learnt as a team. Another staff member told us that if there were any incidents, they would discuss learning points during handovers.
• The provider shared patterns and trends of incidents with the staff team. After the inspection, we received

minutes of a team meeting held the next day where the analysis of incidents was discussed during the meeting.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• There was no established way to share accessible information with people and record and act upon their views. This meant that people did not have a way to voice and understand important issues or develop their wishes and aspirations. In addition, the provider told us that key worker meetings had lapsed. However, communication dictionaries were in place that had information on how to best support people's communication based on their individual needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• People did not receive consistent support with activities. People were left without interaction during our first visit for prolonged periods. For example, one person was seeking interaction from staff but was unable to achieve this so went back to their room and got in bed. Support plans showed that people did not have individualised plans for activities, several people were unable to take part in what activities were available. One person we spoke with told us they liked some activities but not all and would like to go out more.
• However, one relative we spoke with told us in relation to activities, "They've made a real effort to find out [Name's] interests." Another relative told us, "[Activities Coordinator] does a lot of different activities; they were well catered for during COVID."

Improving care quality in response to complaints or concerns
• Not all people using the service had a way to make complaints. There was no accessible, easy read information that people could access to voice their concerns. However, a complaints policy was on display to visitors.
• The provider had systems to review and act upon concerns and complaints. We found no outstanding complaints or concerns.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
•The provider promoted personalised care and people's preferences were reflected in care plans. For example, support plans contained one-page profiles and person-centred information about a person's likes and dislikes.
• People had positive behaviour support plans in place. These plans informed staff how to best support

individuals in crisis or in need of reassurance.

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 our last inspection this key question was rated as good. At this inspection this key question has now changed to requires improvement. 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; promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• People did not experience consistent management and leadership. Several senior managers supported the service in the absence of a registered manager, leading to a disjointed approach to quality assurance monitoring and a deterioration to the service.

• Lack of oversight at the service led to poor medicines management. Processes to audit medication were not robust, which meant errors in medicines administration were not highlighted in a timely way. In addition, there were no systems in place for staff to actively check the stock of medicines before administration. As a result, there had been incidents where people did not receive their medicines as prescribed.

• The provider did not ensure that systems to maintain up to date records were in place. These put people at risk of not having their support needs reflected in records and a delay in medical intervention. We found inconsistency in recording information relating to health and risks to people.

• The provider had not actively sought feedback from people, relatives or other key stakeholders since the last inspection. This meant opportunities to make improvements to the service may have been missed. The provider had completed a staff survey but had yet to analyse and provide feedback on the information to share.

• Processes to mitigate risks and complete outstanding actions were not effective. For example, areas of the environment were in disrepair, giving limited assurance that staff could clean them effectively; environmental and quality audits did not promote accountability to address outstanding actions.

• The provider did not ensure that staff had effective and consistent supervision. This meant that staff were not always supported in their roles and did not have a structured way to give feedback and guidance to improve their practice.

The provider failed to ensure that systems or processes were established and operated effectively. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

• The provider had made statutory notifications to CQC, meeting the requirement to make us aware of any notifiable events.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

• People were not always actively engaged and at the centre of their care. On the first day of our visit there were missed opportunities for interaction between staff and people. However, we observed some positive interactions between staff and people during our second visit. We saw them knocking on people's doors and announcing themselves before entering and people laughing and smiling from interaction with staff.

• A relative we spoke with was positive about the communication they received, they told us; "They [staff] keep me up to date, they tell me about any treatments [person] has had or needs." The relative went on to say the provider always let them know if their family member needed new items or any personal belongings replaced.

• People were offered choices around food. We observed that staff had knowledge of people's preferences around food and accommodated this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not receiving medication safely, environmental risks were not always mitigated and records around support planning and health were not maintained.

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 17 HSCA RA Regulations 2014 Good governance The quality monitoring systems and processes at the service was not robust. The lack of management oversight had impacted on the care people received.

The enforcement action we took:

we issued a warning notice to this provider.