Care Quality Commission

New Park House Limited

New Park House

Inspection report

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15 August 2017
17 August 2017

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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?	**Inadequate** ●
Is the service responsive?	**Inadequate** ●
Is the service well-led?	**Inadequate** ●

Summary of findings

Overall summary

This inspection was undertaken on the 10, 15 and 17 August 2017 and was unannounced. We had received serious information of concern from the local authority (LA) and clinical commissioning group (CCG) following a quality monitoring visit they had undertaken. We found that the provider was in breach of several Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People using the service were experiencing inadequate standards of care that put them at risk of harm. We found that the service was not safe, effective, responsive, caring or well led. We took urgent enforcement action to suspend the provider's nursing registration and to restrict any new admissions into the service. The service has been rated as Inadequate and placed into 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.

New Park House provided nursing and personal care to up to 95 people. At the time of the inspection there were 69 people using the service.

There was a new manager in post who was yet to apply to register with us. 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 2008 and associated Regulations about how the service is run.

People were at serious risk of harm as staff were not meeting people's needs in a safe and consistent way. There were insufficient numbers of suitably trained staff to support people with even their basic needs. Risks of harm to people were not being assessed, monitored or minimised as action was not being taken to mitigate the risk following incident and accidents that had resulted or could result in harm to the person.

People were not being safeguarded from the risk of abuse as incidents of potential abuse had not been

investigated or referred to the safeguarding authority for further investigation.

People's medicines were not being stored, managed or administered safely. People were at risk of not receiving their medication as it was intended, due to a lack of clear and comprehensive information for staff.

People did not receive health care support in a timely manner when their health care needs changed. Staff did not always follow health care advice to maintain people's health and welfare.

People's nutritional needs were not always met. Some people had insufficient amount of food and drink and this put them at risk of malnutrition and dehydration.

The principles of the Mental Capacity Act 2005 (MCA) were not always followed to ensure that when people lacked mental capacity they were supported by their representative to agree to their care, treatment and support. Some people were at risk of being restricted unlawfully.

Staff were not supported to fulfil their roles effectively and there were not enough staff for them to be able to meet people's needs. Poor staff practise was not always identified and acted upon and this put people at risk of receiving unsafe care.

People were not always treated with dignity and respect and their end of life wishes had not been planned for and acted upon.

People's right to privacy was not always upheld and their independence was not promoted. Some people spent long periods of time in bed without being given the choice or opportunity to get up.

People did not receive care that met their assessed needs and their care records did not reflect their current care needs. Details of people's preferences were not always gained or respected due to a lack of available staff. There were limited opportunities available to a small amount of people to engage in social activities. Other people were at risk of social isolation.

People knew how to complain but their complaints were not always acted upon.

There was a lack of clear leadership and clinical oversight throughout the service. The systems the provider had in place had failed to identify areas for improvement and bring about change. The management had not recognised and responded to failings within the service.

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.

People were receiving care that had caused harm and that put them at continuing risk of harm.

People were not safeguarded from the risk of abuse as possible abuse was not being investigated.

There were insufficient suitably trained staff to keep people safe.

People's medicines were not stored, administered or managed safely.

Is the service effective?

Inadequate

The service was not effective.

People's health care needs were not met in a timely manner and people were not being supported with their nutritional needs.

The principles of the MCA were not being consistently followed to ensure that people consented to their care, treatment and support.

Staff were not being supported to fulfil their roles effectively and this put people at risk of receiving poor quality care.

Is the service caring?

Inadequate

The service was not caring.

People who used the service were not treated with dignity and respect and their right to privacy was not upheld.

People were not supported to have a comfortable, dignified and pain free death.

People were not offered choices about their care and their right to independence was not promoted.

Is the service responsive?

Inadequate

The service was not responsive.

People were not receiving care that met their assessed needs and individual preferences.

People's social and emotional needs were not being met.

There was a complaints procedure but not all complaints were managed appropriately.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager in post. There was no clear leadership and clinical oversight.

Action had not been taken to reduce the risk of accidents and incidents following analysis of audits.

The systems the provider had in place to monitor and improve the quality of the service were ineffective.

The provider was not meeting the required expectations of their registration.

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Detailed findings

Background to this inspection

We carried out this urgent inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check 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. The inspection was undertaken following the receipt of serious concerns from the local authority (LA) and the Clinical Commissioning Group (CCG) from one of their quality monitoring visits.

This inspection took place on 10, 15 and 17 August 2017 and was unannounced. The inspection was undertaken by three inspectors at each visit.

During the inspection we spoke with seven people who used the service and observed their and other people's care throughout the service. We spoke with five relatives of people who used the service. We spoke with five members of care staff, the two unit managers, the new manager, the chief executive, the two directors and the nominated individual. We spoke with a visiting GP and members of staff from the LA and CCG.

We looked at people's care records including medication, nutritional and personal care records. We looked at the staff rota's, training files and three recruitment files. We looked at quality monitoring systems the provider had in place such as audits.

Inadequate

Is the service safe?

Our findings

Following the receipt of serious concerns we initially inspected the nursing unit on 10 August 2017. There were 28 people using this service at the time of the inspection. We found serious concerns around the management of people's safety, health and welfare which meant that people were receiving care that was not safe and put them at serious risk of harm. For example, at 11.45am we found that only three people out of 28 people were out of bed and this was not through their choice to do so. We saw these three people sitting in kirton chairs (the Kirton chair's principal role is to provide postural support and promote a healthy, upright sitting position) in the small lounge area situated in the corridor of the unit. One of these people was pushing themselves around and tipping themselves back in the chair in an unsafe manner. They were banging into another person who used the service as they were trying to move around. We saw that the person had their arm stuck in a hole in the chair which was broken. We advised the manager who stuffed the hole with material which we later saw the person take out.

We saw this person had a wet patch on their trousers; we spoke to staff who were unable to see whether the person had spilled their drink or been incontinent. Staff began to push the person in the kirton chair to their room to support them to change however there were no foot rests on the chair so the person put their feet on the floor to try and prevent the chair from moving. The staff member continued to push the chair although the person's feet were on the floor. We intervened as this action put the person at risk of damaging their feet and legs.

At lunchtime we observed one person in their bedroom in a nursing bed (raised off the floor) with bed rails. They had their feet over the top of bed rails and they were attempting to get out of the bed. The person was wearing an incontinence aid and had taken their pyjama bottoms off as they were wet from urine. They looked uncomfortable and were asking for help. Their call bell was on the floor and out of reach. We looked at the personal care records and saw that they had not had their personal needs met that day. We alerted the chief executive to this person's needs who arranged for staff to support the person. We looked at the care records for this person and saw that there were records of this person attempting to get out of bed over the bed rails from June 2017. No action had been taken to reduce the risk of them climbing out of the bed and the person was at extreme risk of harm.

Later in the day we saw another person in bed who looked uncomfortable. They had no way of calling for help if they needed it as there was no call bell. We saw they had slipped down the bed and off the pillows. We noted that this person had very long toe nails which could have compromised the skin if the nails had rubbed against the other leg. We saw no records that confirmed that this person had been offered support with their toe nails and this person was at risk of harm as their needs were not being met safely. This person was also at risk of skin damage. A plan was in place for staff to follow to protect the person's skin from breaking down. For example, to help the person to reposition themselves, applying cream and wearing inflatable boots to alleviate pressure (known as repose boots). The boots had come off so their lower legs were not being protected and the records showed they were not always being supported to reposition themselves in line with guidance and were left in a similar position for hours at a time. This person had developed a skin injury to their heel. This person's health and wellbeing were not being protected and they

were at risk of having further skin breakdown

We checked all people in their bedrooms and saw that they all were late having their basic care needs met. Some people had had very little if anything to eat or drink. We saw records and staff confirmed that people who required repositioning to prevent skin damage were not receiving this care at the times they required it. A member of staff told us: "We are short staffed which means that we can't turn people every two hours as needed, it's usually up to four hours before we get round to it". This meant people were at risk of developing skin integrity issues and their health and wellbeing was not being supported.

At our inspections on 15 and 17 August 2017 of the residential units we found that people were also receiving care that was not safe and that left them at risk of harm. We found that action was not always taken to minimise the risks of harm. For example, we saw records that confirmed that one person who had fell whilst being supported to move using a stand aid. The person's risk assessment had not been up dated and we observed staff supporting the person to use the stand aid in an unsafe manner on the 15 August 2017. On the 17 August we saw that this person's risk assessment had been up dated, however it stated 'to use the stand aid unless agitated and then use the full hoist'. This would continue to put the person at risk as they had fallen using the stand aid and as such should have been assessed as unsafe to use it.

We saw several people who required support with their mobility and examples of when people were not being supported safely. For example, we saw one person had been assessed as requiring support from two staff to mobilise was observed on several occasions on both 15 and 17 August walking unsupervised. On one occasion on the 17 August we observed the person being supported to walk with one staff member. The senior member of staff called to the staff member supporting the person to remind them they needed two staff member, however the staff said: "Don't worry I have two hands". This showed a lack of understanding of the risks associated with not following people's risk assessments and this put this person at risk of harm. We also saw multiple occasions of people being assisted from a sitting down to a standing position by staff. Some members of staff helped people by putting their hand under a person's arm. This is not an appropriate technique as it can cause injury to the person.

On the 15 August we saw one person was purposely sliding themselves out of their lounge chair. We looked at this person's care records and saw that they had been doing this and falling on regular occasions. This person at times became agitated and anxious and cried out. A senior member of staff told us: "We put [Person's name] in their room when they are like that as they are safer". We observed this person in their room on an occasion when staff had supported them to it and saw that they were lying on a normal divan bed and were actually more at risk of falling form the bed than they would have been supervised in the lounge area. We looked at accident and incident records and saw that this person had been found fallen in their bedroom on several occasions. On the 17 August we found that action had still not been taken to reduce the risk of this as we observed this person was left in their room on the divan bed unsupervised for over an hour.

We saw that the same person was prescribed 'as required' medication for 'agitation'. We found there was no protocol for the administration of this medication and we saw it was recorded that this person had been given the medication on a regular basis even though their care notes stated they had been settled. On the 17 August we found that there was still no protocol and we observed the senior member of staff administer the medication after the person shouted out just once whilst lying on their bed where they were allegedly safe. They had recorded 'administered for slight agitation'. We later found out that this person had not had anything to eat or drink for up to 5 hours and this may have been the reason for them calling out.

Over the three inspections of the service we looked at how people's medicines were managed. Medicines

were also checked by a health professional during the inspection of the nursing unit. One person was prescribed some medicine to be taken for seven days; however the medicine had continued to be given for a period of 12 days. The prescription instructions were not being followed and the person was at risk of experiencing potential side effects. Another person was prescribed cream to stop their skin becoming irritated from moisture or irritants. The records showed this cream was not always being applied as prescribed and the person had developed a sore from their skin being moist. We found that medicines were not stored, administered or managed safely and saw several examples of unsafe medicine management. For example, there were no detailed protocols for the use of 'as required' medication such as pain relief and anti-anxiety medications. This meant that staff might not know or recognise the signs of when people required their medicines. We saw gaps in the recording of signatures of when medicines had been administered. This meant that the provider and staff could not be sure that people had had their medicines. The medication clinical room was dirty and cluttered and the medicine trolleys appeared dirty. This meant that people were at risk due to poor infection control measures.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Lunchtime in the dining room was chaotic. We observed people in the dining room asking for their lunch at 13.20. One person said:" I've been waiting for ages where is my dinner"? Another person said: "Is there any for me"? People in the dining room were becoming anxious and agitated whilst waiting. One person was pulling the table cloth off and pushing the table into other people. We asked a member of staff why people were in the dining room and not being offered their lunch. The staff member told us; "We are behind today as we are short staffed. The staff who have come up from downstairs don't know the people so everything takes longer".

At 13.40 one person was observed asking for their breakfast. They said: "I have had no breakfast honest, I wish I was dead, I don't tell lies". A member of staff said: "As soon as I have finished with [Person's name] I will come to you". It was unclear whether this person had had breakfast or was just hungry for their lunch. We intervened and asked a member of staff to get the person something to eat.

We observed relatives coming to the kitchen area at 13.30 and 13.45 as their relative had not had their lunch. We spoke to a relative who told us that their relative had been left in bed for up to three weeks without any explanation as to why. They told us: "My relative is a sociable person and likes company so I don't know why they are in bed". A person we spoke with told us that they had to wait a long time for support. They told us that sometimes due to the wait they became incontinent and were left wet, which they told us made them sore. Other Relatives we spoke with told us that they had identified and discussed the lack of staff available with the management. One relative told us: "We've had relatives meetings but people are not getting the service they are paying for. I have had staff crying on me, they need a leader on every shift. Sometimes my relative can't go the toilet when they want so they soil themselves because there is not enough staff to check on them". Another relative told us: "The staff are doing their best but there's not enough of them." We observed communal areas were often left unattended. One person was sitting in the lounge area in a kirton chair and was draping their legs over the side of the chair. This is unsafe and no staff were present to monitor and support the person from injuring themselves.

We checked all people being cared for in bed throughout the day and had serious concerns about their health and welfare. Some people did not have their basic care needs met all day and some people were not receiving food and drink. We looked at the rotas with one of the directors and they told us how they had been understaffed on the nursing unit due to staff sickness and holidays for a few weeks. We saw that there was only one permanent nurse during the day and the rest were agency nurses. These nurses did not know

people's needs and could not provide the consistent care people required. A health professional told us: "I asked the agency nurse to get me the blood monitoring machine the other day but they didn't know where it was". Another visiting professional we spoke with said the home was: "Very, very short staffed." They also told us they had to wait for people to be got out of bed when they came to visit them and they had to wait for a member of staff to become available to accompany them when visiting people in the residential unit. This was due to staff being expected to go and cover shortages in the nursing unit. The director told us that the previous HR manager had agreed annual leave to too many staff members at the same time and this with the sickness of the nurses had proven difficult to manage.

These issues constitute a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not being safeguarded from the risk of abuse. On the 15 August we saw in numerous people's care records that they had sustained unexplained bruising and injuries which had not been investigated internally or referred to the local safeguarding authority for further investigation. Staff had recorded the injuries but the records had remained on their personal files and no further action had been taken. On the 17 August we found that only one person's unexplained injuries had been reported to the local authority for investigation. This person had had13 separate records of unexplained injuries, however the manager had only referred the one. The director informed us that the previous managers had changed the way that accident and injuries were managed which had meant that senior staff were not being made aware of possible abuse.

On the 15 August we found that one person was being put in their room when they became agitated. This person lacked the mental capacity to agree to this decision. On the 17 August we found that staff had recorded that they had made a best interests decision to put this person in their room, however this had not involved any other agency or representative of the person. This meant that this person was not being restricted of their liberty for the purpose of receiving care without lawful authority.

The issues above are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the way in which new staff were recruited and found that the provider did not always ensure that they gained a reference from the staff member's most recent employer. For example, we saw that the new manager had been employed without a reference from their most recent employer where they had previously been a manager. We were informed that this was because they were recruited through an agency however the provider was still responsible for ensuring that they could be sure that the person was fit and of good character to work with people who used the service.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

At the three visits of the service we found that people's health care needs were not being met or responded to promptly and effectively. We spoke with a visiting GP who also confirmed that their advice was not always followed or their attention drawn to a change in a person's health care in a timely manner. They informed us that they had admitted four people in the nursing unit to hospital on the morning after our inspection of the unit. They had visited to check people's health and welfare after being informed of the findings at our inspection and found that these people were unwell and required medical treatment. This meant that staff had not identified and acted upon the change in these people's health care needs.

The GP gave us several examples of where their advice had not been followed or their advice sought. For example, one person had been prescribed antibiotics for an infection and the GP had asked for the course to continue, however staff at the home had not carried out these instructions. The GP had also asked for an urgent referral to be made to the muscular skeletal clinic and had arranged for a form to be picked up from the surgery. This form was not picked up and the urgent referral was not actioned.

A relative informed us and this was confirmed by the GP that one person had had an infectious rash which was not picked up on by staff when delivering personal care. The rash was identified by a visiting district nurse at a later date as shingles and the GP informed us that this had caused the person unnecessary pain.

Several people had experienced falls which they had received injuries from. We found that prompt referrals to the falls team were not being made to assess the person's needs and to offer support and advice in to how to minimise the risk of falls. For example, one person had experienced falls. A referral had been made to a physiotherapist after a delay of nine days. When the physiotherapist visited they recommended a GP reviewed the person in relation to falls. The GP visited the person later the same day, however feedback from the physiotherapist was not given to the GP and there was a further delay in seeking medical assistance. The physiotherapist also recommended the person should pause once standing prior to starting walking. We observed this guidance not being followed by staff. We observed that some people were having difficulty in sitting in certain chairs and that some people were at risk due to trying to stand up when they were not safe to do so and mobilising in chairs which were not fit for use. Referrals to the occupational therapist or physiotherapists had not been made for them to recommend and offer advice as to the best chairs or equipment that was suitable for the person to maintain their safety.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's nutritional needs were not being met. We saw at our inspection on 10 August of the nursing unit that people were not being offered sufficient food and drink that met their assessed needs. We saw that several people were not offered any food or drink all day due to a lack of available staff. For example, one person at 15.45 had only been offered a small bowl of porridge and a cup of tea. This person's nutritional plan stated that they preferred finger foods however a member of staff from the CCG informed us that the day before our inspection they had found that a plate of bacon eggs and a crumble and custard had been

found uneaten in their bedroom. The care records did not state that the person had refused the food and no support was available to this person to eat the food and drink offered. This put this person at risk of malnutrition as they were not being supported to eat and drink in a way that met their assessed needs.

We saw several people who had drinks in their rooms which were out of their reach as they were in bed. One person was heard shouting: "I am thirsty, please get me a drink". We checked and saw that this person had a drink but it was out of their reach. We noted that the person's drinks required thickening and the drink available to the person had not been thickened. This put this person at risk as some staff working in the nursing unit did not know people's assessed needs and may have given this person the unthickened drink.

We observed that one person on the nursing unit was brought their lunch at 13.45 in their bedroom. The food had been pureed and the member of staff told us that it had been reheated in a microwave. The food looked congealed and overcooked. A visiting relative told us: "I don't know why my relative is having a pureed diet they never used to have one". We checked this person's care records and there had not been an assessment from a speech and language therapist (SALT) to recommend a pureed diet. We asked the member of staff to change the meal to a more appetising meal that met their needs.

We saw another person in the residential unit had been assessed by SALT as requiring a pureed diet due to being at risk of choking, however we saw that this person had been offered and ate biscuits which are contrary to the guidelines for a pureed diet. This put this person at risk of choking.

Another person on the residential unit had been in their room for the day as staff told us they had been anxious. At 14.10 we asked a member of staff if this person had had any lunch. The member of staff told us that another member of staff had told them to tell us that the person had had some lunch when actually they had not. This meant that this person had not had anything to eat since breakfast and this staff member had been encouraged to lie to us by their colleague.

We saw that numerous people had records that showed they had lost weight, however action was not always taken to gain health advice and support. For example, we saw one person had lost 8.5 kg in a month and their care records stated in July: GP to be informed. The GP had not been informed and the person was at risk of malnutrition. Another person had lost weight in a two week period which staff had documented and noticed but they had not taken any action to prevent the person from losing any more weight. This meant people were not being supported to maintain their health and wellbeing.

These issues were a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 found that some people were being restricted of their liberty unlawfully. For example, one person was being put in their room when they were agitated. This person had not had their mental capacity assessed in relation to this decision and the decision to do this had been made by staff working in the service. No other health or social care agency

had been involved in the decision to restrict this person to their room and an application for a DoLS in relation to this restriction had not been made.

We found that people were not always consenting to their care or being supported to consent to their care through the principles of the MCA when they lacked the mental capacity. For example, we saw one person's medicine records that they had been administered 'as required' anti-anxiety medication at the request of a relative and not based on the person's need for the medicine. The lack of a clear medication protocol did not support staff to make an informed decision to administer the medicine. There was no evidence to support the fact that the relative had lasting power of attorney for 'health and welfare'. The law states that one adult cannot consent for treatment of another regardless of their relationship status unless they have lasting power of attorney rights.

These issues constitute a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not being supported to fulfil their roles. Some staff did not have the skills and knowledge of people who used the service to be able to care for them safely. The nursing unit due to a lack of permanent nurses had had to deploy agency nurses which had impacted on the quality of care. The agency nurses were not leading the staff team and did not know the needs of people they were caring for. During the inspection on the nursing unit staff informed us that they were not able to meet people's needs due to a lack of suitable staff. One staff member told us: "What can we do? The staff have to come upstairs from the residential unit and they don't know people and that means things don't get done".

Within the residential units we saw that senior staff were not supporting the care staff to be effective in their roles. We observed poor and unsafe moving and handling of people on both days of our inspection in these units. Although senior staff were present they did not act to stop and redirect staff into best practice and we found that their own practice was not always competent. For example, one senior member of staff administering 'as required' medication with no protocol and a moving and handling plan had been up dated with incorrect information on it about the measurements of a sling to be used with one person. The director and chief executive told us that over a period of a few weeks, competent permanent staff had either gone off sick or had been allocated annual leave which had left the service short staffed. This put people at risk of harm as not all staff were competent and effective in their roles.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

Most people in the nursing unit were observed to be in bed throughout the day and there was no evidence that these people had been assessed as requiring to stay in bed for their health needs. This did not promote people's independence and offer them choice, respect and autonomy. We observed that one person who was in bed at 12:48 was very distressed and upset. They told us: "I don't want to be in bed all day. I'd rather die than live like this." They went on to say: "I pray over and over for the Lord to take me, it's no life." A carer entered the room at 12:50 to tell us they had offered this person to get up this morning but they'd said they were tired so wanted to stay in bed. We informed them that this person clearly now wanted to get out of bed and the carer said they would go and get someone. The person said: "They [the staff] always say they're busy with other people. They just pass the door and don't say anything. They promise but they never do." At 13:12 the carer had still not returned and the person was getting more distressed. We went to get a member of staff and upon our return one of the Director's, was trying to comfort the person. At 13:20 another member of staff attended with a hoist and commenced supporting the person out of bed.

On the nursing unit we found several people in a state of undress in their bedrooms with their bedrooms doors open and clearly on view to passing visitors. For example, one person had been incontinent and had taken off their pyjama bottoms and was wearing just a wet incontinence pad and a pyjama top. Another person was in their room being visited by their relatives. The relative told us: "My relative has just a vest and incontinence pad on. They are not incontinent but since coming here a few weeks ago they [the staff] have put a pad on her. She hates it and is able to ask to go to the toilet". The relative also told us that they did not know why the person was being cared for in bed and had been for the previous three weeks. They told us that the person had not had a bath or seen the hairdresser for this amount of time and that they liked to look nice and have their hair done. We saw that staff had recorded that this person had become aggressive and unsettled when having their incontinence aid changed. This did not demonstrate that this person was being treated with dignity and respect. This left the person feeling embarrassed as they had lost their independence to be able to use the toilet and get out of bed.

Another person we spoke with told us that although they didn't need to wear an incontinence aid but they chose to as they had to wait so long for staff to be able to support them to the toilet. They told us that sometimes they had to use the aid and then wait for staff to help them change and this embarrassed them. We also noted that this person had a moisture lesion and being in a wet incontinence aid would aggravate the skin and make it sore.

Several people on the nursing unit were poorly and had been admitted into the service for end of life care. The National Institute of Clinical Excellence (NICE) guidelines state that' Care at the end of life should be responsive to the personal needs and preferences of the person who is dying. Discussions with the person can identify any existing expressed preferences for care, such as advance care plans, and explore their goals and wishes, preferred care setting, current and anticipated care needs and any cultural, religious or social preferences. This information will be captured in an individualised care plan'. We saw that not everyone had an end of life care plan in place. For example, one person who had been admitted with a long term

condition which could deteriorate at any time did not have a care plan. The GP told us that they had prescribed end of life medication for this person to be given at the time their health condition deteriorated. However, there was no end of life plan put in place for this person with the details of their choices and medication and an agency nurse was on duty the day this person's health deteriorated. As they were not aware of the plan of care and the medication they required this person was admitted into hospital. The distress and suffering of this person could have been alleviated if there had been a clear and comprehensive end of life plan and the staff caring for the person had been made aware of this.

We observed that staff were mostly kind and caring in their conversations with people. However, they lacked the time to be able to spend with people to even meet their basic care needs. A member of staff told us: "I don't feel like I have the time to give the care I should". Within the residential units, one member of staff had told another member of staff to lie to us about one person having their lunch; this did not demonstrate respect for the person from this member of staff. We saw one person in the slumped in a wheelchair which was broken and had a deceased person's name on it. This did not demonstrate respect for the person or the deceased person. We asked the person if they were uncomfortable and they told us they were not comfortable. We sat with the person talking and reassuring them and we saw that staff had noted the person was uncomfortable but they did not offer to support the person into a more comfortable chair until we intervened.

We noted another person had their socks on inside out with their name on a label clearly showing. We observed another person calling out and staff ignored them. This person was eventually put in their room as staff told us they were safer there, yet staff had not attempted to reassure or redirect the person. We saw one person was asleep in their room in the morning, the domestic staff member had entered their room, propped their door open and begun cleaning their room. These interactions did not demonstrate that staff were treating people with dignity and respect and that their right to privacy was upheld.

At 18.50 on the evening of 17 August we observed one person ask to go to bed. The carer responded: "You've got to stay in the lounge because you keep falling." We asked the carer why they couldn't go to bed. They responded by saying: "We've been overruled by the seniors and told they us they can't go." This did not show respect for the person's choice to go to bed.

These issues constitute a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People throughout the service were not receiving care that was personalised and that met their individual assessed needs. When people's needs changed the staff and provider did not respond in a timely manner to ensure that people's needs could be safely met. For example, we saw that when people fell that action was not always taken to minimise the risk and people's risk assessments were not always updated to reflect the change in need. For example, one person had fallen six times in six weeks. We saw that in this person's care records it stated that they were supposed to be checked on every 30 minutes when in their bedroom. However, we saw on one incident record that this person had been found on the floor in their bedroom after at least 2.5 hours of being there before being found. Staff had not followed the person's care plan and this had meant that this person did not receive the care they were assessed as requiring. The manager told us that they were investigating this incident however the person's risk assessment had not been up dated to reflect the incident and reduce the risk of it occurring again.

We saw other examples of where people's assessed care needs were not being met. Some people were not receiving the diet they had been assessed as requiring, other people were being moved unsafely as their individual needs had not been assessed or staff were not following people's care plans. For example, one person required to be sitting on a pressure cushion and regularly repositioned to prevent sore skin. We saw that this person was not always sitting on a pressure cushion and was not repositioned as described in their care plan.

Another person's needs had changed since coming out of hospital. Staff told us that the person had become more agitated and anxious. We observed staff trying to support this person and saw they were having difficulty in meeting their needs as their behaviour had become disruptive. The staff had resorted to isolating the person as they did not know how to care for them. Following the inspection, several people within the residential units were assessed by the LA and their needs were identified as requiring nursing care. This meant that the service had not being meeting these people's needs and prompt action had not been taken when a change in their needs had been identified by the staff caring for them.

People's care plans and risk assessments were not all up to date and reflective of their needs. One relative we spoke with said: "We weren't involved in writing my[relative's] care plan. We weren't asked any questions." This put people at risk as new or agency staff would look at the care plans for information on how to care for people. For example, the agency nurse who was not aware of one person's end of life plan as it had not been completed and not handed over to them. We spoke with a social worker who had come to assess one person's needs and they told us how difficult it was to gain accurate information about people as the records contradicted themselves. For example, one staff member had recorded one person as weighing a certain weight and another record of the same date referred to a different weight.

The National Institute for Clinical Excellence (NICE) states that people who provide accommodation to older people should 'offer regular group and/or individual sessions to encourage older people to identify, construct, rehearse and carry out daily routines and activities that help to maintain or improve their health and wellbeing'. We found that most people were not offered regular opportunities to engage in activities of

their choices. People within the nursing unit experienced isolation whilst in their bedrooms and were not offered any opportunity for activity. One person on this unit told us: "I go to bed early as there is nothing else to stay up for". Another person on the residential unit told us: "All I do is sit in this chair, looking at the door hoping I can go". When asked if they were bored they told us: "Bored? I'm going crazy". Other people who were living with dementia required more support and innovative ideas to encourage them to become involved in any activity and staff lacked the time and skills to be able to engage them.

These issues constitute a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints procedure however we found that not all complaints were acted upon. A relative told us that they had recently complained about the fact their relatives wheelchair had gone missing and also some nightwear. They told us that they had asked why their relative was being left in bed and they had not received a satisfactory response to these issues. All these issues were evident for this person on the day of the inspection and not been addressed.

This was a breach of Regulation 16 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

The service lacked clear leadership and clinical oversight despite there being a new manager in post. New Park House had been without a stable and consistent manager for approximately two years. The senior management team had responded to previous concerns identified at previous inspections; however they had been unable to sustain and maintain a good quality service. This meant that people had received a poor and inadequate standard of care which left them at risk of harm.

We were alerted to serious concerns at the service by the LA and CCG and we (CQC) responded by initially inspecting the nursing unit. We found serious concerns and found that people were at extreme risk of harm. We took urgent action to suspend the provider's nursing registration and to restrict any new admissions into the service. We found that staffing levels were inadequate to keep people safe as the unit was being managed mainly by agency nurses who did not know people's needs. One of the directors informed us that the HR manager had allocated too much annual leave to too many members of staff at the same time, plus there was some staff sickness. This had caused the reduction in effective staffing levels and had resulted in an inadequate standard of care being delivered. This did not demonstrate effective management and leadership of the service.

Staff we spoke with following the suspension of the nursing unit told us that they had been informing management that they were not able to meet people's needs in the unit. One staff member told us: "I've been concerned about the unit for about a year, we didn't have enough time to give people food and drinks, all the seniors knew what it was like". Another member of staff told us: "I wrote a letter requesting I came down from the nursing unit, I didn't feel I could give the care I should". We fed this back to the nominated individual who said: "I don't know who they have spoken to, we obviously need more whistle-blowers don't we?"

Following the inspection of the nursing unit we returned to inspect the residential units. We found further concerns within these units and we asked for an action plan of how the provider planned to mitigate the risks to people. We informed the local authority who advised the provider to engage with a consultant to support them in making improvements to the quality of the service quickly. On receipt of the action plan we were not reassured that the provider had recognised the seriousness of the concerns and that they had full accepted responsibility for the poor standards of care.

We returned the following day and found the full senior team were not present. We were told that two of the senior team had been at the service all night. We spoke with the new manager and one of the directors and found they had not taken the advice given from the LA and involved a consultant. They showed us that they had made referrals to health professionals such as the falls team and physiotherapists; however these were completed by fax with just the names of people with no information on their individual needs. This would have made it difficult for the professional to be able to prioritise the people who required urgent support. The provider also told us that staff had been briefed on the concerns following our feedback on 15 August, for example regarding moving and handling. When we spoke with staff on 17 August some of them were not aware of the outcome of our visit and were not aware of concerns.

Staffing levels had been increased in the residential units because of the staff transferring from the nursing unit. However, we saw that the units still lacked clear leadership and oversight. The senior staff were not identifying and acting upon poor staff practise. We fed back our concerns about the senior staff's competency to manage and deliver good care as we had observed them not following people's risk assessments/care plans and not following safe moving and handling procedures themselves. This meant that care staff were not being given the guidance and support they required to be able to fulfil their roles and improve the quality of the care they delivered.

Any audits being completed had been ineffective in identifying concerns and improving the quality of service. The care plan audits had not ensured that people's care records were up to date and reflective of people's needs. There were gaps in the recordings of when people's needs should have been met and we saw that people who should have had hourly or two hourly checks or repositioning were not receiving these. The medication audit had not identified and improved the safe management of medication that we and the other agencies had identified. We saw that some audits of medicines had identified the same concerns on multiple occasions, showing that action had not been taken to resolve them. People were at risk of not having their medicines as prescribed due to the lack of information available to staff and the ineffectiveness of the medicine audit.

Lessons were not being learned and acted upon in relation to accidents/incidents and falls. We saw that falls were analysed and we could clearly see that the majority of unsupervised falls had occurred between the hours of 20.00 and 8.00am. We discussed this with one of the directors who said they too had noticed this. However they had not taken any action to minimise the risk of people falling during these hours even though it had been identified as a time of greater risk.

Safeguarding referrals were not being made. We saw numerous unexplained injuries and bruising to people recorded on people's care records, however no action had been taken to investigate these concerns or refer them to the LA for further investigation. The director told us that the previous managers had changed the reporting system and this had proved ineffective as the appropriate staff were not being made aware of the injuries and the need to report them.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the final visit we informed the LA of our on-going concerns who arranged for a member of their staff to be at the service to support and coordinate the care within the two units. The provider informed us that they had employed a consultant to advice on making improvements to the quality of the service.

During the visits we found that the provider had not been notifying us of all significant events that had happened within the service as they are required under the registration to submit. We use this information to monitor the service and ensure they responded appropriately to keep people safe. This meant we could not always be assured they were dealing with incidents and issues in an appropriate way as the CQC was not always being informed of incidents.

This was a breach of Regulation of 18 of the (Registration) Regulations 2009.

We saw that the provider was not displaying their most recent inspection rating as they are required to do. Ratings must be displayed in the premises where a regulated activity is being delivered from within 21 days of the report being published on the CQC website.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.