

Parklands Care Services Limited

The Parklands Care Home

Inspection report

26 Ellison Street
Thorne
Doncaster
South Yorkshire
DN8 5LD

Tel: 01405812233

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

The Parklands Care Home is a residential care home providing personal care for up to 40 people. At the time of our inspection there were 27 people using the service. Some people using the service were living with dementia.

People's experience of using this service and what we found

The provider had a system in place to monitor the quality of the service, however, this was not always effective. There was a lack of leadership and governance and this impacted on the service provided to people. There was little information to show people and their families had been communicated with and kept informed about the service and their family members.

Risks associated with people's care were identified but not always managed safely. We found care plans lacked important information to assist staff in providing safe care. We carried out a tour of the home and found some concerns regarding infection prevention and control. Some areas of the home needed a deep clean and some areas were poorly maintained. There was little evidence to show lessons had been learned when things went wrong. People mainly received their medicines as prescribed. However, we informed the registered manager of some minor issues and they took appropriate actions.

People were safeguarded from the risk of abuse. There were sufficient staff available to meet people's needs. Staff were recruited safely and had pre-employment checks to determine their suitability for employment.

People were supported to have maximum choice and control of their lives and staff support people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 22 June 2018).

Why we inspected

The inspection was prompted in part due to concerns received about infection control, care planning, governance and risks. A decision was made for us to inspect and examine those risks. We looked at the key questions of safe and well led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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.

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Parklands Care Home on our website at www.cqc.org.uk

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

The Parklands Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was carried out by two 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.

Service and service type

The Parklands 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. The Parklands is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and five relatives about their experience of the care provided. We spoke with five members of staff including the registered manager, deputy manager, and care workers.

We reviewed a range of records including four people's care records including multiple medication records. We reviewed a variety of records relating to the management of the service. We looked at two staff files in relation to recruitment and staff supervision and observed staff interacting with people.

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

- Risks associated with people's care were identified but there was a lack of guidance for staff in how to support people safely. For example, one person required the use of a hoist to transfer, however, no sling size or indication of how to use the sling, was documented in the person's care plan.
- One person was at risk of falls and had a sensor mat in their bedroom. However, this was not mentioned in the person's care plan and therefore there was no instructions for staff to follow.
- We found prescribed thickener stored in unlocked cabinets in a communal area. This posed a risk of choking.

Risks relating to the welfare of people were not always effectively managed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We carried out a tour of the home with the registered manager and found many areas that required attention. Many areas required a deep clean, storerooms were untidy, and items were stored on the floor making cleaning difficult.
- We were somewhat assured that the provider was using PPE effectively and safely. PPE was available around the home; however, we saw clean PPE on a cleaning trolley which also had dirty items on it. Some staff wore their own clothing and inappropriate footwear. Some staff work long sleeved clothing and false nails. All these things did not promote effective infection control.

The provider had failed to ensure infection, prevention and control policies and procedures were always followed. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

- The provider was facilitating visits for people living at the home to maintain contact with family and friends.

Using medicines safely

- People received their medicines as prescribed. However, some topical creams were not signed for when administered and some liquid medicines did not record the date they had been opened.
- Some people were prescribed medicines on an as and when required basis, often known as PRN.

Information about how and when to take these medicines was available.

Learning lessons when things go wrong

- The registered manager kept a record of all accidents and incidents. The record showed people had been referred to professionals such as the falls team when required. However, there was no detailed analysis of trends and patterns to help mitigate future risks. For example, there had been a high number of unwitnessed falls, but no analysis to identify any potential hazards.

Systems and processes to safeguard people from the risk of abuse

- People were protected from the risk of abuse. Staff told us they received training in safeguarding and knew how to recognise and respond if they suspected abuse.
- People and their relatives felt the service was safe. One person said, "I feel safe and some of the staff know me well." One relative said, "I am not sure what else they could do for [family member]. She is safe and being looked after. I've not had any problems. All the staff are friendly."

Staffing and recruitment

- Staff were recruited safely and had pre-employment checks to determine their suitability for employment.
- We observed staff interacting with people and found there were enough staff available to meet people's needs. However, one relative said, "I don't think there is enough staff. There used to be more."

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

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 we rated this key question good. At this inspection the rating has 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.

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

- The provider did not always promote a positive culture and people did not always receive person centred care. For example, one person was spending time in their room and had a tube of cream in their room belonging to someone else, someone else's name on their bedroom door and no stimulation to occupy them whilst alone.
- Confidential information was left unattended in communal areas.
- Care plans were contradictory and did not always reflect people's choices and preferences.
- Relatives felt involved in the planning of care for their family member and people told us they felt cared for. One person said, "They [staff] look after me alright. I can't grumble."

Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems in place to monitor the quality of the service were ineffective. We raised concerns about infection control, risks, medication and the governance of the home. These issues had not previously been addressed.
- There was a lack of provider oversight which had failed to determine poor standards.
- There was limited evidence that people and their families had been involved in the service. One relative said, "I've not been asked for any kind of feedback."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The management team consisted of the registered manager, deputy manager and a team of senior care workers. However, there was a lack of leadership which demonstrated they did not always work effectively as a team.
- The management team understood their legal requirements and could evidence notifications had been made to CQC and to the local authority when required. However, there was a lack of understanding around quality performance and meeting standards.

Working in partnership with others

- The provider did not always work effectively with others.
- The local authority had raised concerns with the home prior to our inspection and had given opportunity for the management team to action concerns. There was no evidence these issues had been addressed.

We identified a lack of person centred care, leadership, engagement and ineffective management systems. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Risks relating to the welfare of people were not always effectively managed. The provider had failed to ensure infection, prevention and control policies and procedures were always followed.

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 We identified a lack of person centred care, leadership, engagement and ineffective management systems.

The enforcement action we took:

Warning notice