Parkgate Manor

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Parkgate Manor is a residential care home providing personal care to 24 people at the time of the inspection. The service can support up to 40 people. The service is a large manor house, set in private grounds within a small rural village. Some people have specialist needs associated with downs syndrome, autism or dementia. A number of people have age related health conditions such as diabetes or mobility issues.

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

Right Support
The model of care and setting did not always maximise people's choice, control and independence.

People were not always supported to have maximum choice and control of their lives, but staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

There were systems to ensure people's needs were assessed but people and their relatives, where appropriate, had not been involved in the process. Significant progress had been made to increase opportunities for people to participate in activities, but further work was required to make activities more person centred. The design and layout of the premises was centred on communal living and did not support the promotion of people's independence.

Risks to people were assessed, monitored and managed safely. People's medicines were managed safely. The systems in place ensured that people were protected from abuse and improper treatment. Parkgate Manor was kept clean. There were enough staff to safely meet people's needs. Emphasis had been placed on ensuring that staff had the skills, knowledge and experience to meet people's needs.

Right Care
Care was not always person-centred or promoted people's dignity, privacy and human rights.
Some staff practices although well intentioned were institutional and did not enable people to make informed choices. For example, people were served tea with milk already included. There were not enough opportunities to enable people to share their views about how they were supported.

Recording did not always demonstrate that people's assessed needs were being met. It was recognised

however, that the electronic care planning system was still in its infancy and with further training for all staff this could eliminate some of the shortfalls found.

Staff were caring in their approach and people responded warmly to them. People had increased access to activities, external entertainers were visiting the service and there were opportunities for people to go out more.

Right culture
The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure all people using the service could lead confident, inclusive and empowered lives.

Systems to obtain people's views were not effective either through keyworker meetings or surveys and further work was needed to adopt a more person-centred approach to enable people's individual views to be sought. There were no recent surveys to seek the views of people's relatives. Staff morale had improved and whilst staff had opportunities to share their views at meetings, further development was needed to ensure there were increased opportunities for staff to attend supervision meetings.

The systems for auditing of care plans and health checks were not effective, and this left the risk of issues not being identified quickly and support sought. Auditing in relation to infection control, health and safety and medicines were clear and thorough and any shortfalls found had been addressed promptly.

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 Inadequate (published 14 March 2022).
This service has been in Special Measures since 14 March 2022. At this inspection we found the provider remained in breach of regulations. However, during our inspection the provider demonstrated that some improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last 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 coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from Inadequate to Requires Improvement.

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 continued breaches in relation to person centred care 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was not well-led.

Parkgate Manor

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 could 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
There was two inspectors on the first day of inspection and one inspector on the second and third days.

Service and service type
Parkgate Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement dependent on their registration with us. Parkgate Manor 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 the information we held about the service and the service provider. We looked at notifications

and any safeguarding alerts we had received for this service. We sought feedback from the local authority and professionals who work with the service. Notifications are information about important events the service is required to send us by law.

The provider was asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection
We spoke with six people and observed staff interacting with others to help us understand the experience of people living at the service. We spoke with eight staff, an agency staff member, all members of the management team, the cook and a maintenance staff member. We spent time reviewing records, which included five care plans. We looked at two staff files and documentation related to the management of the service such as accidents and incidents and medicines management. We also looked at staff rotas, and records relating to health and safety and the management of the home. Following our inspection, we also spoke or received correspondence from four people's relatives and from four professionals. We also continued to seek clarification from the provider to validate the evidence found. We looked at training data, care plans for two people, quality assurance records and meeting minutes.

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 inadequate. 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.

At our last inspection the provider had failed to ensure lessons were learned when things went wrong. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

Learning lessons when things go wrong

- Records were kept of all accident and incidents. Some records were more detailed than others and some were based on assumptions of what had happened rather than facts. Although staff felt supported, there were no records of a debrief following incidents to discuss what had happened, to check if staff were ok and to assess if the guidelines had been followed, if they worked, or if they needed to be amended. The registered manager had already identified that this was an area that needed to be improved.
- Observations at previous inspections had identified that mealtimes were not always monitored effectively. Mealtime monitoring had been introduced and a member of the management team was always on hand to ensure that everyone had a pleasant experience, and to be on hand if staff needed any support. All staff told us this worked well, and people appeared very relaxed at mealtimes.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess, monitor and manage the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- Records for people prone to constipation were not always completed. Staff told us this was either lack of recording or because sometimes people used the bathroom independently. Because there was no flag on the system to monitor gaps in recording, no assessment was made to check if further treatment was needed.
- One person needed their bed to be at a set elevation for sleeping as they were prone to having chest infections. There was no monitoring tool in place to ensure this was done. Another person had a health condition that meant staff needed to carry out set procedures three times a day and take appropriate actions depending on the outcome. Records were not always consistently completed. When we discussed this with the registered manager flags were placed on the electronic system to remind staff. We assessed the

lack of recording as low impact as neither of these people had required hospital admissions and the local hospital had praised the staff team for their management of one person's needs and the work carried out to prevent hospital admissions for this person.
● One person had received dietetic support and was refusing food and fluids at the time of inspection. The person's GP was aware of this. Records showed the limited intake of fluids but not what was offered and did not demonstrate how staff had encouraged fluids. This was assessed as a records issue.
● Apart from one agency staff member who had worked in the home a long time, only permanent staff supported people who were at risk of choking. This ensured that people received support from staff who knew them well and how they needed to be supported.
● If anyone needed a positive behavioural support plan this had been written, reviewed and updated. These plans ensured staff knew how people were when they were happy and what support was needed when they were anxious or in crisis. They enabled staff to support people consistently and ensured people felt as safe as possible at a time of anxiety.
● Each person's needs in the event of a fire had been considered and each had an individual personal emergency evacuation plan that described the support they needed. There were systems to carry out regular health and safety checks including checks on gas and electrical appliances safety. Water temperatures were monitored regularly. A legionella risk assessment had been carried out to ensure the ongoing safety of water. Areas that we noted in need of repair had already been highlighted and were on the maintenance plan for action. Monthly checks were also carried out on all equipment in use in the home.

Staffing and recruitment
At our last inspection the provider had failed to ensure staff had the right skills and experience to safely meet people's needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● There were enough staff to meet people's needs safely. There were a couple of staff vacancies on day shifts and these hours were covered with the use of agency staff. Most agency staff had worked at the home for a long time and knew people well. Two people were funded to receive one to one support throughout the day and this was clearly documented on handover sheets and was observed throughout our inspection.

● There were two waking staff and a sleep-in staff member at night. Staff told us there were enough staff to meet people's needs safely. There were on call procedures for staff to gain advice and support if needed outside of office hours, and at weekends. A cleaner had just retired, and another had moved over to the caring side. Two new staff had been appointed subject to recruitment checks. In the interim, the general manager and care staff were helping out with cleaning tasks and records of regular cleaning and auditing were kept.
● Extensive training had been provided to staff since our last inspection to ensure all staff could meet people's needs.
● There were safe recruitment checks carried out. Checks had been completed before staff started work at the service including references and employment history. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
At our last inspection the provider had failed to ensure that medicines were managed safely. This was a

breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● There were safe procedures to ensure medicines were correctly ordered, stored, given and recorded appropriately. There was guidance for staff on how each person liked to receive their medicines.
● Some people receive medicines on an 'as and when required' basis (PRN) for example, for pain relief or anxiety. Protocols described specific advice on when these medicines should be used.
● Staff had received training in the management of medicines. In addition, they were assessed in terms of competency before they were able to give medicines. A health professional told us, "It's been a while since I visited but support was gratefully received, and I felt there were positive vibes in the home."
● Audits were carried out at weekly and monthly intervals and where actions were noted, these were addressed promptly. The storage area had been painted and new flooring had been fitted.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider failed to ensure systems and processes protected people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People told us they were safe. Some were not able to tell if they felt safe, but we observed people to be relaxed and content in their surroundings. People's relatives told us their loved ones were safe. One relative told us, "When I talk with (person), she seems to be happy with the place where she lives and feels safe."
● Staff had a good understanding of how to make sure people were protected from harm or abuse. We asked a staff member about the reporting procedures for abuse and they gave a very clear response. All staff had received safeguarding training and knew how to recognise signs of abuse.
● All staff had been enrolled on a bespoke positive behaviour support course. This was run by the local community learning disability team and involved three days of training. The first group was just about to complete the course and dates were booked for the remainder of the staff team.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● The provider had not admitted any new people to the service since our last inspection.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
People were supported to receive visitors in line with government guidance.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At our last inspection there was a failure to assess and design care to ensure people's preferences were achieved and their needs met. This was a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found significant progress had been made in relation to assessing people's needs in relation to how they expressed their emotions, but further work was required to ensure people's day to day needs were up to date and accurate. The home remains in breach of Regulation 9.

● There was no system to ensure that referrals made for professional advice and support were always followed up. We found one person had experienced a seizure and they had no known history of epilepsy. Records did not describe the seizure in detail and would not have assisted a professional in making a judgement about the incident. Although a referral had been made to an epilepsy service, staff could not tell us if the person had been seen or if the appointment had been chased.
● Records showed another person had been referred to a memory clinic but there was no record if the person had attended the clinic or if anyone had followed up to see if an appointment had been made.
● One person's relative told us about a delay in arranging screening to be carried out for their relative and that this may have delayed treatment for their loved one. This was being investigated at the time of inspection.

Failure to assess and design care to ensure people's needs are met is a breach of Regulation 9 (Person-Centred Care) of the Health and Social Care Act 2008 (Regulated Activities)
2014.

● The home was in the process of transferring all care plan documentation onto an electronic system. Each person's needs had been assessed. There had been some teething problems with the system, and it was not working to its full potential. See well led key question. Paper records were still in place so staff could refer to if needed. Staff used apps on mobile phones that provided information of the support people needed so would not always need the level of detail in the assessments. Staff were able to tell us about people's needs and how they should be supported.

● Everyone had been referred to the local dentist service, we were told that quite a few had been seen and others were awaiting appointments. Referrals had been made as needed to the local speech and language therapy team and where appropriate, there were guidelines to support staff in assisting people with eating and drinking. We saw that these were followed.
● A health professional told us, "People are getting older and alongside their learning disabilities they have very complex health needs. Staff are tuned in and know when to ask for help. We don't get silly or inappropriate requests. When situations arise, we come up with solutions together."

Staff support: induction, training, skills and experience

At the last inspection we found staff had not received appropriate support, training and personal development to carry out their duties This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18. However, further improvement is needed to ensure that all staff had regular access to support and supervision.

● Staff gave us mixed feedback on support and supervision. Each of the management team had responsibility for providing supervision and some provided supervision more regularly than others. Two staff felt that senior management did not work with care staff enough to provide support but that they received good support from their immediate line managers. One staff member said that there was always support when they looked for it. Records showed that whilst some staff attended regular supervision meetings, others had not attended any.
● There were other ways that staff could receive support such as breakfast meetings that were held two to three times a week where staff discussed people's needs and staff told us they could use these meetings to ask for support and guidance if needed. We also saw that staff meetings were held.
● Staff received a programme of training to ensure they could meet people's needs effectively. This included a mixture of e-Learning and classroom-based training. Essential training included safeguarding, moving and handling and infection control.
●Specialist training was provided on subjects such as epilepsy and dysphagia, food and nutrition and dementia. A number of staff had recently completed a three-day bespoke positive behavioural support training course and there were dates booked for the remainder of the staff to attend this course. One staff member told us, "We were given homework, to get a family member to brush our teeth so we could experience what it felt like. I now understand what that's like so know what people feel, it wasn't pleasant, and it has helped me to adapt my approach."
● Staff that were new to the service, were supported to complete induction training in accordance with current good practice. A staff member told us they had shadowed an experienced staff member for two weeks. They said that could have been extended if they had needed extra time. They told us they used this time to get to know people, to read care plans and to complete online training.
● Agency staff completed an induction to the service and received training via their agency. There was an expectation that staff would read risk assessments and care plans for the people they were supporting. An agency carer told us they felt part of the team and felt staff gave people a good quality of life.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection there was a failure to ensure service users consent to care and treatment had been sought in line with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

At this inspection we found improvements had been made and the home was no longer in breach of Regulation 11.

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

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Decision specific assessments were carried out to determine people's individual ability to make decisions about their care or how they lived.
● We saw that people's capacity to make decisions had been assessed in a wide range of matters, for example dental care and support with medical interventions. Where people were assessed as not having capacity to make decisions a best interests meeting had been arranged to seek the views of relatives and professionals and a record was kept.
● Records clearly demonstrated if people had a DoLS authorisation and why, and staff had received training on DoLS and mental capacity. Staff told us they always sought consent from people before carrying out any support and we saw this during our inspection.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink a range of foods that met their individual choices and needs. Everyone we spoke with told us the food was good and we saw very little waste. The chef told us that after breakfast, everyone was given two meal choices for their main meal. We noted that when meals were served, people were asked if they were happy with their meal choice. We saw two people requested and were given an alternative meal and one person asked for a second helping and this was provided. Another person showed no interest in their food, so an alternative was provided.
● Staff had sought advice from the speech and language team in relation to supporting people who had difficulty swallowing and were at risk of choking. There were detailed guidelines in place and staff were seen to follow them. People were supported at their own pace and the mealtime was not rushed.
● In addition to the main menu there were separate menus for two people who had specialist dietary needs. Some people's diets were adjusted to cater for their diabetic needs, some meals were pureed, and some meals were served moist.

Adapting service, design, decoration to meet people's needs
● Parkgate Manor was not designed to support people with physical or a learning disability. Although there was a stairlift on the main stairway, people needed to be fully mobile as there were areas not covered by the stairlift. As vacancies became available on the ground floor these rooms were offered to people at risk of falling or those who needed support with the stairs.

● Other than redecoration of vacant rooms no plan to look at appropriate modifications or structural alterations and additions had been made to meet the individual needs of the people who lived there. For example, assessing if anyone would benefit from an ensuite bathroom or if one person or a small group could have an additional lounge/kitchen area to develop independence skills.
● Whilst people had been involved in personalising their bedrooms with ornaments and pictures, most not been given the opportunity to choose the colour schemes for their individual rooms. The registered manager said there was no reason why people could not be involved in choosing colour schemes for their rooms as and when they were decorated. One person had chosen their colour scheme, and they told us they were very happy with their choice.
● A number of people had ensuite toilets or bathrooms and those that did not, only had to share a bathroom with two to three other people. Whilst bathrooms and toilets were functional, they were not homely.
● There were two large lounge areas, a conservatory and a large dining room. People chose where they would like to spend their time. Some people chose to spend time in the garden.
● There were various seated areas in the garden and the maintenance person told us they were gradually opening up other areas of the grounds for safe use. There were plans to make the front garden more secure so that people could come and go more easily. Some people liked to spend quite a bit of their time in the garden and we saw that those who needed support were assisted to spend time there.
● The service had a small day centre to the rear of the building. This included a hairdressing salon, a kitchen area, computer and a tv. At the time of our inspection this area was mainly used to facilitate visitors to the service. The hairdressing salon had been reopened and there were plans to reopen the kitchen area to involve people with opportunities to cook/bake with staff support.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At our last inspection there was a failure to ensure people were always treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that although significant progress had been made, some of the practices, due to the size of the home and the routines, remained unintentionally institutional. Not enough progress had been made and they remained in breach of Regulation 10.

● Some staff practices although well intentioned were institutional and did not enable people to make informed choices. We observed a staff member offering a choice of tea or coffee and they spent time making sure that each person understood the choices they were making. However, the tea and coffee was served in flasks with milk already included. This did not give people the opportunity to choose if they wanted their drinks black or with a little or a lot of milk.
● Records showed that a friend of one person had made an unplanned visit to Parkgate. As the person was about to start lunch the friend was asked to wait. It was not clear from records if the person had been informed their friend was in the home and staff could not tell us. The friend waited but could not stay too long as they were reliant on transport so did not get to see the person. We discussed this with the registered manager who said they would offer an apology to both and arrange a further visit.
● The rotas demonstrated that time was set aside for keyworkers to spend time with people. It was not evident from records that this always happened. Guidance to staff on the use of keyworker time referred to spending time with people whilst tidying wardrobes. Some records demonstrated that staff used the opportunity to chat with people about a variety of topics, but most records focussed on demonstrating that wardrobes were tidy rather than on time to hear people's views. Staff told us they did not really understand what was required for keyworker time. We discussed this with the registered manager who agreed the purpose of keyworker time needed to be clarified.
● Before the COVID-19 pandemic, some people used to attend church on a regular basis. We were told that people had lost confidence and did not want to go out to the church. There were no records of any measures taken to reassure individual people and staff were not able to tell us that this had been done. No one had asked if individuals would like a member of the church to visit them in the home. The registered

manager told us they would speak with each individual to check their wishes.
● Most people in the home were retirement age and did not have specific goals that they were working towards. However, care plans detailed what people could do and what they needed support with to maintain their skills and independence. For example, personal care support or helping around the house with tasks such as emptying bins, folding laundry, laying and clearing the tables. Further work was required to determine if some people wanted to work towards further independence in particular areas.

The provider failed to ensure that people were always treated with dignity and respect and this is a continuing breach of Regulation 10.

● People were supported by staff who knew them very well. Staff used a warm and caring approach and they regularly checked with people to make sure they were ok. They knew people's likes, dislikes.
● We observed one person was sitting in the laundry folding clothes and spending time with the staff member. We were told people generally didn't take part in laundry, but some brought clothes to the laundry for washing and others liked to put their clothes away once they had been laundered. Some people independently took their plates and cups to the trolley when they finished their meal.
● A staff member told us, "When (person) came to Parkgate we couldn't get a flannel near them but now (person) will let you wash them. Sometimes they say, 'I don't want it' and you try again later, and they are willing to have a wash."
● Staff ensured people's privacy, dignity was always promoted. A staff member told us, "We always knock on people's doors before entering. When we support people with moving in the lounge, we always use a screen." We saw this happened during our inspection. We also saw staff speaking discretely with people if they needed to use the bathroom or if they needed support to clean their face.

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 inadequate. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection there was a failure to ensure people received person-centred care. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection although the provider had made progress, there was not enough progress made and they remained in breach of Regulation 9.

● Care plans did not accurately describe each person's individual needs. The home was in the process of moving all care plans to an electronic system. The vast majority had been completed. The process for each person was lengthy and no one had examined the full documents for accuracy.
● We found numerous inaccuracies in the information provided in care plans, areas that were either unclear or needs that had not been explored. For example, one person's care plan said they did not like a bath/shower, but staff told us the person regularly had a shower. Two people's care plans stated they had dementia, but staff told us they did not. In one care plan it stated the person needed a plastic cup and plate for meals, but later said they used a ceramic plate. These inaccuracies would not support agency or new staff to support people.
● Daily records were completed on electronic devices and staff used icons for specific areas of support. The icons gave a generic explanation that was not always person centred. For example, one person's record for an activity stated, local community, it stated how long they had been out and that there was a social benefit, was happy. Some people's records were more descriptive and explained what people had been doing, how they had made choices and if they had enjoyed what they were doing. On day two of our inspection we saw that memos had been sent to staff to show staff how to write in a more person-centred way.

The provider was not ensuring people received person-centred care. This is a continuing breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When a person's needs changed, relevant sections of care plans were updated and were sent in a memo to staff. We saw that staff signed to acknowledge they had read memos. This system worked well, and staff told us they found this useful.

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

● At our last inspection people had stopped going out of the home during the COVID-19 pandemic and many had been reluctant to return to this ever since. At this inspection two new activity coordinators had been appointed, one full time and one part time. Progress had been made in increasing the activities provided and this was considered an ongoing project to make activities more person centred.

● External entertainers were now coming into the home regularly. This included, Elvis the impersonator, a piano accordion player, pet pals and a magician. Trips to the seafront, cafes for cream teas, and places of interest were being provided. One person attended a work placement for a few hours weekly.

● A staff member told us, "The new activity coordinator is spending time getting to know people and what they want to do. It's a tough job as a lot of people don't want to go out, they like quieter activities and it takes time to get to know each person."

● We observed a variety of activities throughout our inspection. Some people participated in a parachute target game and a beanbag game, others were supported with colouring, crafts, time spent in the garden and walks around the grounds. People were actively involved and there was a good competitive spirit. One person who staff said would not normally participate was happy to get involved. Another person told us, "I like colouring, I do it every day."

● A new hairdresser had recently started to come to the service. The service had a hair salon situated in the day centre. Some people still chose to go to Hastings for hairdresser appointments.

● Staff told us one person who had refused all opportunities to go out, recently agreed to go on the bus on two occasions when staff were collecting another person from an activity. Staff were hoping that this might encourage the person to eventually agree to an external activity, something that staff felt confident they would enjoy once experienced.

● Staff told us that when they took one person out to the local town, they were amazed at the extent of their local knowledge. They were planning to take the person out on a one to one to spend more time with this person and hear their stories.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● Staff knew people well and how they communicated. Each person's communication needs had been assessed and recorded. Whilst some people found it easy to communicate their needs and wishes, others could choose from two choices by pointing to a right or left hand. We saw that staff were quick to pick up on people's communication and offer support accordingly.

● One person was supported to do video calls with their relative who lives abroad. The relative told is this was, 'Really appreciated.'

● Easy read literature was used for some people to explain hospital appointments.

Improving care quality in response to complaints or concerns

● There were systems to ensure anyone wanting to raise a concern could do so. Whilst most people would not formally raise a concern, staff told us they would know if people were unhappy or upset through how they expressed their emotions. For example, if a person did not eat a meal an alternative would be provided, if they walked away from an activity, they would be offered an alternative. We saw that this happened during our inspection and staff acknowledged people's wishes.

● People's relatives told us they would feel comfortable raising concerns if they had any. A relative told us, "I am happy with the care provided but if I had concerns, I would contact them."
● There was a complaints procedure, and this was available in an easy read format that was displayed. There was also a suggestions/comments box at the front door to enable anyone to give feedback if they chose to.

End of life care and support
● The home used a 'When I die' booklet and some people's relatives had discussed their wishes with them. Others chose not to discuss the subject but said they would discuss it in the future. In one person's care plan we saw that the home recorded how the person had grieved following the death of a close relative. There were prompts for staff to watch out for in the future should a similar event occur.

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 we rated this key question inadequate. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last two inspections a failure to ensure quality assurance and governance systems were effective meant a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made or sustained and the service remains in breach of Regulation 17. It is acknowledged that since the last inspection a new registered manager had been appointed and needed time to get to know people and staff. In addition, they had introduced a new electronic care planning system and a number of the shortfalls in record keeping should be addressed once the system is operating effectively.

● The process of auditing care plans had been delegated to a senior staff member, but there were no records to demonstrate this had been done and no oversight to monitor that it had not been done. Senior staff told us they needed more training on the system to be able to carry out audits effectively.
●There was a lack of oversight in relation to health records. The home had not identified that records related to some people's health needs (constipation, fluid intake and epilepsy) had not always been recorded. There was a weekly phone call or face to face meeting with the local GP to discuss people's health needs so this lowered but did not reduce fully the potential impact of things being missed. There was a lack of monitoring to ensure that all health referrals were followed up with specialist professionals.
● Although systems had been set up to ensure staff received regular supervision, this was not effective for all staff. Some staff had attended more than one meeting since July 2022 and others had not attended any. Records did not show that any staff had received a staff appraisal. Staff did have access to breakfast meetings and occasional staff meetings. They told us they felt supported by some senior staff but not all. Some staff felt that some senior management did not spend enough time working with people and staff.
● Staff were clear about who they should report to if they had problems. A staff member told us, "We know it gets passed on to senior management and we get feedback, (management team member) is brilliant." Another staff member told us, "I can see the difference I make here, and it is rewarding. I feel proud of my work and what I have achieved."
● Paper based systems to audit and monitor infection control, health and safety and medicines were clear and thorough. All shortfalls found had been addressed promptly.

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

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There was a lack of understanding of how to apply person centred care in a large setting. 'My Voice' meetings were introduced in April 2022 and were meant to be quarterly. However, they were not completed for everyone and were not done in August. The registered manager knew that they needed to introduce different formats in line with people's needs but this had yet to be done. Key working time was set aside on the weekly rotas but this was not consistently done and had not been reviewed or adapted. Some people's relatives did not know the names of staff who were keyworkers for their family members.

● Relative surveys had not been completed since the last inspection. Relatives told us they were confident that staff would let them know of any changes to their family members' needs or health. However, three relatives said they used to receive newsletters and they would love them to be reinstated. Two relatives said, they would like to know more about the activities people did. One relative said, "We were told about the last inspection, they were very open and promised it would improve but then, silence. I want to know what has been done."

● A staff survey was due, and the registered manager sent this out following our first inspection day. 13 staff responded and there was a mixture of positive and negative responses. The general manager said the wrong format was sent and the format used had been one that was sent when there was a particular issue to be addressed. They confirmed the format would be reviewed and reissued so that staff views could be gained, analysed and actions taken where appropriate to address the negative issues.

● When we talked with the registered manager and staff about the vision for the future, no one was able to tell us. The general manager told us all staff had been given information about right care, right support, right culture which talks about the support people with a learning disability and autistic people should receive. However, it was not clear that they had looked as a team at how to apply this to people living at Parkgate Manor.

● At the last inspection there was a negative and closed culture. This had improved greatly, and morale was much improved. There was a vibrant atmosphere in the home when we visited. However, most staff told us there was still scope to improve this further. Staff meetings had provided staff the opportunity to raise any concerns they had, and breakfast meetings were held two to three times a week to provide opportunities to improve communication within the home. Staff spoke positively of these meetings. We were told that at the end of each day senior management did a walk around the home to check if everyone was ok but there were no records of these.

The failure to ensure quality assurance and governance systems were effective, risks to people's safety were identified and managed safely, records related to the provision of support for people were adequately maintained, service performance was evaluated and improved is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

At our last inspection there was a failure to ensure that all incidents were reported internally and externally and a failure to work in partnership effectively with other agencies. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of these elements of regulation 17.

● The registered manager was aware of the statutory Duty of Candour which aims to ensure providers are open, honest and transparent with people and others in relation to care and support.

● The registered manager was open and knowledgeable about the service and the needs of the people living there. They had been aware of the last inspection report when they took on their current role and knew that it was going to take time to make the improvements required. They understood their role and responsibilities to notify CQC about certain events and incidents and had reported appropriately.
● Since the last inspection the registered manager worked closely with the local authority market support team who had provided advice and guidance to help them make improvements to the service.

Continuous learning and improving care
● Since the last inspection emphasis had been placed on staff training and staff had attended or completed online training in a wide range of subjects. The registered manager said the next step was to have staff working as champions in certain areas. Some staff had already completed train the trainer courses in moving and handling and safeguarding and there were plans to increase the numbers of staff trained.
● Mealtime monitoring was introduced to ensure there was always a senior observing that people had a pleasant experience and that their needs were met. Following recent training on PBS a staff member told us. "I stop and think, how can I explain or word things differently to get a better response from someone and it has really helped."
● The registered manager told us they had weekly phone calls from their GP surgery which enabled health reviews to be done and was an opportunity to monitor people's medicines and answer any queries they had.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people received person-centred support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were always treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure quality assurance and governance systems were effective.