Mrs Kim Crosskey

Pearson Park Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Pearson Park Care Home is a residential care home providing accommodation and personal care for up to 24 people, some of whom may be living with dementia and mental health support needs. At the time of inspection there were 14 people living at the service.

People's experience of using this service and what we found
The provider had made limited improvements at the service since the last inspection and people continued to receive unsafe and ineffective care. Improvements found at the last inspection had not been sustained or embedded. This led to additional breaches in regulation at this inspection.

People were not always treated with dignity and did not receive timely care in line with their needs and preferences. Staff did not recognise when people required assistance and they did not receive appropriate training to support them to deliver effective care. Some improvements had been made to the management of medicines. However, improvements to documentation and the use of topical medicines were still required. We have made a recommendation about this.

The environment continued to require maintenance and areas of the service were not clean or well maintained. Risks to people were not always identified, recorded, or mitigated.

People were not always supported to have maximum choice and control of their lives. However, 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 was a lack of effective leadership and the provider's values were not always followed by staff. The provider did not effectively assess areas of safety and quality to ensure people received a good level of care.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 09 February 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations and continues to be rated inadequate.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection. We undertook a focused inspection to review the key questions of safe, effective, 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 remains inadequate. This is based on the findings at 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.

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

Enforcement and Recommendations
We have identified breaches of regulation in relation to assessing risk, premises and equipment, person-centred care, dignity, staff training and governance. We have made a recommendation about management of medicines.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Pearson Park 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.

Inspection team
1 inspector completed the inspection.

Service and service type
Pearson Park Care Home 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. Pearson Park Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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. 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 the provider, deputy manager, 2 care workers and 3 people who used the service and 3 relatives. We reviewed a range of records. This included 4 people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

Inadequate

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. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to assess and monitor risk. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 12.

- The provider continued in their failure to identify, assess and act on risks to people to keep people safe from the risk of harm. The provider had not always assessed and managed risks relating to people's specific health conditions.
- Daily records and monitoring charts did not reflect the care people received, and they did not always serve to effectively monitor people's health and wellbeing.
- One person's Personal Emergency Evacuation Plan did not reflect their current needs. This placed this person at risk of harm in the event of fire or emergency situation.
- Fire safety measures were not robust and exposed people to risk in the event of a fire. For example, several fire doors did not close properly. We reported our concerns to the fire service.
- Accidents and incidents were not always recorded and opportunities to learn lessons and prevent similar incidents from happening again were missed. For example, care plans and risk assessments had not always been updated following accidents to ensure people received the right support.

The failure to assess and monitor risk was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded following the inspection and told us they would review risks to people and produced evidence of action taken in response to the incidents that had been identified at the inspection.

Using medicines safely

At our last inspection the provider failed to have systems in place for the safe administration of medicines. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of

Regulation 12 in respect of medicines management.

● Improvements had been made to the administration of time specific medicines.
● Improvements were still required to ensure people received their medicines in line with prescribers' instructions. Topical medicines were not always applied in line with the prescribers' instructions and documentation to support the application of these medicines was not always available.
● Medicine records we reviewed were not always completed in line with best practice guidance and administration dates were not always accurately recorded.

We recommend the provider revies best practice guidance for the safe management of medicines and updates their practices accordingly.

Staffing and recruitment

At the last inspection we recommended the provider continued to review the numbers and deployment of staff to ensure they were meeting people's needs. The provider had made improvements.

● Recruitment systems were not robust enough to ensure staff suitability was assessed. For example, employment history was not always explored and right to work checks were not always completed.
● There was enough staff to meet people's needs.

Preventing and controlling infection
● The provider was not promoting safe hygiene practices to prevent and control the spread of infection.
● Some areas of the home were visibly dirty. Some equipment used within the service was dirty and worn and effective cleaning was not always possible.
● PPE was stored in an unclean plastic storage organiser.
● Monthly infection control audits had been completed but these did not reflect the findings at this inspection.

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were in place to record any concerns of a safeguarding nature.
● Staff were aware of their responsibilities to safeguard people.

Visiting in care homes
● The provider was supporting visiting in line with government guidelines.

Inadequate

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. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs

At our last inspection the premises were not properly maintained and had not been adapted to meet the needs of people using the service. This was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 15.

● Areas of the service continued to be poorly maintained and unclean such as flooring and paintwork. The provider's action plan failed to drive forward improvements in a timely manner.

The failure to ensure the service and equipment were maintained and clean was a continued breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

At the last inspection systems were either not in place or robust enough 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.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 9

● People did not always receive the support they needed to eat and drink. For example, staff did not offer to cut up people's food.
● People's food and fluid intake was recorded by staff. However, these were not reviewed or monitored by staff to ensure people received adequate food and fluid intake.
● People were not offered a choice in line with the menu and people raised concerns about the variety and quality of the food provided. One person told us, "I'm sick of having jam sandwiches." Another person told

us, "My meal was cold at lunchtime." Menus showed that meal choices were repetitive.
● Staff did not always recognise when people required visits from health care professionals.

This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

At the last inspection we recommended the provider sought guidance and advice regarding MCA practice and updated their practice accordingly. The provider had sought advice regarding MCA. However, records were not sufficiently robust.

● People received care in line with the principles of the MCA. However, documentation was not always completed in line with best practice. One person's capacity assessment was completed after the best interest decision was made.

This was a further breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At the last inspection we recommended the provider ensured prompt completion of all training and continued to monitor and review the training for staff, based on the current needs of people living within the service. The provider had not made improvements.

● The provider had not taken action to ensure staff completed appropriate training based on the current needs of people living within the service.
● Shortfalls remained in staff training for MCA, diabetes and falls and fragility training.
● During the inspection we identified poor staff practice which compromised people's dignity and put people at risk of harm due to poor skin care. Staff were not supported to receive training in these areas.

The provider had failed to make improvements and ensure staff were supported through training to deliver the requirements of their role. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People needs were not always assessed prior to their admission to the service.
● Care plans failed to provide clear guidance for staff to follow on how to deliver effective care to meet people's diverse needs. One person was admitted into the service without any assessments of their current needs being completed or recorded.
● Best practice was not always followed when people were admitted to the service and the provider failed to ensure they followed their own admissions policy.

Inadequate

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. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection we found that due to poor governance of the service people were placed at risk of harm. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Despite recurring breaches of regulations and the widespread and significant shortfalls identified at the last inspection, the provider had taken limited action to improve their oversight of the quality and safety of the service. Systems and processes in place to monitor this remained ineffective and did not pick up the areas found at this inspection.
- Recommendations made at the last inspection had not been acted on and had led to further breaches of regulations.
- Effective governance systems were not consistently applied. There was a lack of overarching governance from the provider and the service continued to lack leadership.
- Records were not always organised, legible, or robust. For example, records of staff supervision were unclear and medicines and MCA records did not follow best practice guidance.
- Records did not contain personalised information about people's needs, the specific risks they were exposed to or their preferences about how they wished to receive their care.
- The provider had not reviewed people's care plans to ensure that people's care and support was up to date and current

The provider's continued lack of oversight and ineffective audit systems placed people at risk of receiving unsafe care. This was a continued breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had employed a consultant to support them to make improvements, however, only limited improvements were evident.
- The provider was in the process of updating care plan into a new format. However, on the first day of inspection only two care plans had been updated since the last inspection.

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

- People did not always receive dignified, person-centred care and improvements were needed to develop the culture at the service.
- Staff did not recognise people's care needs and communication with people was not always respectful.
- Staff did not always recognise when people required support or care. For example, one person's dignity was compromised during the inspection when personal care was not provided until this was raised by the inspector.
- People's personal preferences and choices were not always considered by staff or the provider.

A failure to ensure staff treated people with dignity and respect is a breach of Regulation 10 (Dignity and Respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 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

- The provider understood their requirements under duty of candour.
- The service continued to work with external professionals when required.
- The provider sought feedback from people, relatives, and professionals.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people were treat with dignity and respect.