

Valley Park Care Centre (Wombwell) Limited

Parklands Care Home

Inspection report

Park Street
Wombwell
Barnsley
South Yorkshire
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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Inadequate 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

Parklands care home is registered to provide accommodation with residential and nursing care for up to 52 adults, including those living with dementia and mental health needs. The home is located in Wombwell, near Barnsley and situated within grounds shared with two other care homes owned by the same registered provider.

We have inspected this location on two previous occasions and found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This inspection on 30 January and 21 February 2017 was to check improvements had been made to meet the breaches of regulation. The inspection was unannounced. This meant the people who lived at Parklands and the staff who worked there did not know we were coming. We found sufficient improvements had not been made to meet regulations.

There was no registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager who was running the home at the last inspection had left, a new manager had commenced employment.

Some families expressed they did not always feel their relative was safe at the service because of incidents that happened that had either harmed their relative or others. The number of incidents was supported through notifications submitted to the Care Quality Commission (CQC).

We found staffing levels were sufficient to meet people's needs, but the recruitment of staff still required improvement to include all the relevant information and documents as required by the regulations.

Systems were in place to manage risks to individuals and the environment, but we found those systems were not always effective in practice to manage the risks identified.

Systems and processes were in place for the safe administration of medicines, but we continued to find the management of medicines required improvement.

There continued to be inconsistency where care plans and risk assessments did not fully reflect a person's needs, concerns we had raised at previous inspections.

The majority of people received good support and choices at mealtimes, but this was not consistent for everyone who used the service, in particular people receiving their meal from a drinking beaker. For those people there were risks in regard to their nutritional needs, the presentation was not appealing and the people would not have been able to identify individual food by taste.

The premises had been improved to take account of 'best practice' in their design for people living with

dementia, but further improvement was required. The registered provider had an action plan in place to address this.

Supervision of staff took place, but there was no information to demonstrate staff's performance had been appraised yearly as stated in the service's policies and procedures. All training was not up to date, or effective in practice, in particular, fire training.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, we found where decisions had been made in people's best interest, some decisions lacked evidence to support the person lacked capacity in accordance with the Mental Capacity Act 2005.

People had access to a range of health care professionals to help maintain their health.

There were mixed responses from families about the care their relative received.

There were systems in place to assess and monitor the quality of service provided, but these had not been effective in achieving compliance with regulations.

The local authority and clinical commissioning authority were working with the service to drive the required improvements.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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."

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Improvements were still required around the management of medicines, including acting on gaps in medicine administration records, stock tallying with medicine administration records and ensuring people received their medicines as prescribed.

We found staffing levels were sufficient to meet people's needs, but recruitment of staff continued to require all the relevant information and documents as required by the regulations.

Systems were in place to manage risks to individuals and the environment, but we found those systems were not always effective in practice to manage the risks identified.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Supervision of staff did take place, but appraisal had not taken place in accordance with policies and procedure and all training was not up to date, or effective in practice, in particular, fire training.

Improvements were required around demonstrating people lacked capacity when best interest decisions were made for them and the environment.

The majority of people received good support and choices at mealtimes, but this was not consistent for people who had their meals from a drinking beaker.

Is the service caring?

Requires Improvement ●

The service was not always caring.

There were mixed responses from relatives about staff maintaining respect for their family members, without them having to prompt staff, particularly in terms of their cleanliness.

There were some positive interactions between people who used

the service and the staff supporting them, with staff supporting people in a professional, but kind manner.

Is the service responsive?

The service was not always responsive.

People's care records were not always an accurate reflection of their current care and support needs and staff had not always responded to people's needs in a timely way when their needs had changed.

Stimulation for people had improved, with more meaningful activities available for them and staff having individual time to spend with people reminiscing.

There was a complaints procedure in place, but actions were taken without full investigative action of the root cause for the complaint, so further complaints could be minimised and decisions made in people's best interests.

Inadequate ●

Is the service well-led?

The service was not well led.

There was no registered manager. The registered provider was not fulfilling their obligations to display the rating for the service on their website.

There was inconsistent management of the service.

There were systems in place to assess and monitor the quality of service provided, but these had not been effective in achieving compliance with the regulations.

Inadequate ●

Parklands Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 January and 21 February 2017 and was an unannounced inspection, which meant no-one at the service knew we would be visiting. On 30 January 2017 the inspection team consisted of two adult social care 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. On 21 February 2017 the same two adult social care inspectors continued the inspection.

Before our inspection we reviewed the information we held about the service and the registered provider. This included the service's inspection history and current registration status and notifications the registered person is required to tell us about. We also reviewed safeguarding information we had received.

We also contacted the local authority contracts and safeguarding team and Healthwatch (Barnsley). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with three relatives. We also spoke with the manager, deputy manager, two care staff, the activity co-ordinator, two cooks, a domestic, the administrator, the regional support manager and the regional manager.

We observed care to help us understand the experience of people we could not verbally communicate with, spending time in communal areas and observing how staff interacted with people and supported them.

We spent time looking at records, which included three people's care records, six staff records and other records relating to the management of the home, such as training records and quality assurance audits and reports.

Is the service safe?

Our findings

We continued to find people's medicines were not managed in a safe way.

Improvements had been made since the last inspection with some systems and processes for medicines. For example, we did not find any out of date medicines, body maps and/or tracking systems were in place for people who had medicines administered via 'patches' applied to their person and there was more detailed information for people who took medicines 'as required', so staff were clear about what this meant. However, for two people we found 'as required' medicines prescribed for agitation had been administered, when the daily progress record did not support the person required the medicines, in accordance with the protocol.

The nurse on duty was responsible for people's medicines. We saw when they gave people their medicines, the medicines were placed in individual pots and a drink made available. When they went to the person to administer their medicines, we saw they greeted the person and observed them while they took their medicines. Staff were patient and caring when administering medicines and this was done in a courteous and unobtrusive way.

We saw controlled drugs were in use at the service. Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation, which means there are specific instructions about how those drugs are stored and dealt with. This includes the record of the administration of those medicines. We found controlled drugs were dealt with in accordance with the legislation.

We found medicines were securely stored in locked medicine trolleys, which were stored in locked rooms when not in use.

We inspected four people's medication administration records (MAR) and found concerns with three of them. The concerns included five gaps in the MAR that had not been acted on, an inability to tally the stock of four medicines, which on some occasions were associated with the gaps in records we had found and two medicines not being administered for at least two days because of a change in prescription and the change in dosage of those medicines being unavailable. We also found where people had been asleep at the time of the usual medicines administration, these had not been administered at a later time.

Our findings meant medicines continued not to be managed in a safe way and was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

We checked and found the systems in place to recruit staff that were fit and proper persons to be employed continued not to fully meet regulations and therefore there was a risk that people were supported by staff who were not suitable to work at the service.

The recruitment and employment policy/procedure did not include all the information and documents that must be obtained to comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2010. Schedule 3 is a list of information and documents that must be in place for staff that are recruited.

We inspected the recruitment records for two staff members who had commenced since the last inspection when concerns about compliance with the recruitment process had been identified. The records contained a range of information, but each record did not include all the information and documents specified in Schedule 3.

This demonstrated a continued breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked that sufficient numbers of suitable staff were on duty to keep people safe and meet their needs.

The manager provided information about the ratio of staff to people. They told us currently there were 16 people who lived at the home, two of whom required one to one supervision between 8am and 8pm and one who required one to one supervision between 9am and 8pm. In addition, there was a further three members of care staff to care for and supervise the remaining 13 people. A nurse was on duty to provide the nursing care that all people living there required. Between 8pm and 8am there was one nurse and three members of care staff.

We checked the staff rosters between 23 January and 21 February 2017 to confirm what the manager had told us. We found the numbers of staff correlated, but that out of 60 nursing shifts, 25 were covered by agency staff. This meant whilst there was insufficient permanent nursing staff who were knowledgeable about people's needs and the policies and procedures of the service the service were trying to maintain some continuity by using the same agency staff.

In addition to nursing and care staff, the home employed an administrator and ancillary staff that included domestics, maintenance staff and cooks.

From our observations we noted staff were visible around the home. We saw staff did not rush people whilst supporting them. We saw that people receiving one to one care and supervision had a member of staff with them at all times. We heard few call alarms during our inspection, but when we did they were responded to in a timely way.

Our discussions with people's family members did not raise any concerns about the numbers of staff available.

When we spoke with staff they confirmed the staffing numbers identified were typical of the numbers they experienced. Staff told us most of the time they were able to meet people's needs, although there were some days when people's behaviour required closer observation, which made them struggle to keep up to date with tasks.

We found the systems in place to manage risks to individuals and the service was not sufficiently robust to keep people safe.

Individual risk assessments were in place for people who used the service in relation to their support and care, for example, mobility, falls, skin integrity and malnutrition. We found in two of the care files we reviewed care plans had not been updated in a timely manner, in accordance with current risks presented. For example, one person's care needs had changed significantly within a short period of time and they were

being cared for in bed. The only way to identify those changes was to read the monthly evaluations. For another person, care staff had raised concerns about the risk of choking because of family bringing foods that were not pureed, where the care plan identified this. The care plan did not provide assurance the need for a pureed diet was the result of assessment from a specialist in people's nutritional needs and this could not be confirmed by staff. This demonstrated a failure to ensure risks were robustly assessed and an accurate reflection of people's needs.

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

Systems were in place to monitor the safety of the building and the equipment in use within the home such as bed rails and profile beds, staff call systems, window restrictors, water quality, water temperatures, legionella, fire and electrics. We found improvements were required so that risks identified were acted on in a more timely way to keep people safe. For example, fire drills had highlighted a lack of staff knowledge of the action to take in the event of a fire, where bed rails were broken and not repaired this was escalated to the manager and that window restrictors met health and safety guidelines.

We checked people were protected from bullying, harassment, avoidable harm and abuse that may breach their human rights.

Relatives we spoke with were not all confident their relatives were safe. One relative said, "No I'm not happy, I don't feel as if [relative's] safe. Twice in two weeks a male resident has hit my [relative] and they know what he's like. I don't want [relative] being hit. It was in the morning [early hours] and again on another night. It's always the night staff that let it down. Last week [relative] scalded her leg with a hot cup of tea. [Relative] doesn't have milk in the tea and the night staff didn't cool it down."

We looked at the service's safeguarding policy procedure. This contained out of date information and lacked detail about the procedure to report an allegation of harm, including who to report to and the procedure for reporting.

Staff confirmed they had been provided with safeguarding vulnerable adults training so they had an understanding of their responsibilities to protect people from harm. Staff could describe the different types of abuse and were clear of the actions they should take if they suspected abuse or if an allegation was made so that correct procedures were followed to uphold people's safety. Staff knew about whistleblowing procedures. Whistleblowing is one way in which a worker can report concerns, by telling their manager or someone they trust. This meant staff were aware of how to report any unsafe practice. Staff said they would always report any concerns to the qualified nurse, home manager or registered provider.

The registered provider had submitted 18 notifications in relation to allegations of abuse since the last inspection. CQC's internal analysis of information provided by the home shows us that they have a high level of reporting allegations of abuse. This indicated systems and processes were in place to report allegations of abuse, but actions taken as a result of the allegations may not be sufficient to mitigate ongoing risk. The service did not have a system in place to analyse the incidents.

Is the service effective?

Our findings

We checked that people consented to care and treatment in line with legislation 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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At previous inspections we had confirmed the service had policies and procedures in place in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

There was a system in place which provided an overview of the information about DoLS. For example, the names of people for whom a DoLS had been applied for, dates DoLS had been authorised and when staff needed to re-apply for a DoLS if that was still appropriate. Having this overview helps to ensure senior staff have oversight of relevant information pertaining to DoLS authorisations. However, there was one instance where a DoLS application had been made and one of the conditions was that the managing authority should notify the supervisory body of any significant changes in their care, support and/or treatment that could impact on the level of restriction and this had not been done.

We found the service had not improved all of their records to demonstrate that consent was sought in accordance with the MCA where people lacked capacity to give consent, for example, care delivery and decisions were made in their best interests.

Staff told us they had completed training in MCA and DoLS and this was also evidenced on the training matrix. Staff understood people's right to make decisions and understood some people may be able to make simple decisions but not more complex ones.

This meant there was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked whether people were supported to have sufficient to eat and drink and maintain a balanced diet.

To do this we viewed people's nutritional assessments and associated care plans, and observed the breakfast and lunch time meal. We also spoke with people's families about the mealtime experience.

People's nutritional needs had been assessed during the care and support planning process and people's needs in relation to nutrition identified, but the rationale for the dietary needs was not always clear. This included three people being provided their meal from a drinking beaker. Staff we spoke with could not explain why people were being given their meal in this way. This meant the meal was not presented in a way that looked appetising, there was a risk the meal was not the appropriate consistency and the person would not be able to identify individual food tastes.

The menu board in the dining room described the meal for the day, including in a pictorial format.

Our observation of the breakfast and lunchtime services found people were better supported than on the last inspection. People were offered the choice of moving to eat at a table in the dining room or remain where they were. People were provided with a verbal and visual choice of their meal. This meant people were more engaged in the decision making about their meal. We saw one person visibly sit up in their chair to look at the meals offered and decide which one to choose. People were offered condiments and sauces and we saw one person ate two meals. For people in the main dining and lounge area people that needed assistance to eat were supported by staff and aprons were used to protect their clothing where appropriate. The meal was unhurried and not task focussed. The food looked and smelt nice and was hot. Communication between people and staff was good throughout the meal and we heard staff asking people if they had enjoyed their meal and did they want anything else or more.

However, further improvements were needed because we found one person who remained in bed, whose lunchtime meal had been missed. When we viewed their food chart it recorded they had not eaten since breakfast. Discussions with staff identified a member of staff had assisted the person with a drink and a snack mid morning but staff were unable to explain to us why the person had been missed at lunchtime.

This meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked that staff received training, supervision and appraisal so they had the knowledge and skills to provide effective care to people.

Staff told us the training provided gave them with the skills they needed to do their job.

Training records showed induction training was provided that covered mandatory subjects such as health and safety, safeguarding and people moving people, but some staff were still not up to date with all their training.

The manager provided a training matrix, the record by which training was monitored so that training updates could be delivered to maintain staff skills. Training included, dignity, fire, first aid, health and safety, food hygiene, infection control, moving and handling, safeguarding, care planning, reporting, dementia awareness, MCA, medicines, moving people, nutrition and person centred care. The numbers of staff attending relevant training for their role had improved since the last inspection. However, we found not all training had been effective. For example, people had received fire training, but when a fire drill was activated there was a lack of staff knowledge in the action to take to keep people safe.

When we spoke with staff most of them told us they received supervision, but could not always recall the frequency.

The manager provided the supervision matrix to verify the supervision staff had received. Supervision is the

name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. We found most staff were receiving supervision at the services required frequency of three sessions a year, but most of these had been part of a group meeting to identify areas of improvement for all staff.

Appraisals are meetings involving the review of a staff member's performance, goals and objectives over a period of time, usually annually. These are important in order to ensure staff are adequately supported in their roles.

The staff training and development policy stated all staff members should have their performance appraised at least annually. The appraisal system was not in place by the current management team, as they had not been at the service long enough to appraise staff. The manager told us she wasn't sure if there was an appraisal matrix for 2016 and she did not know which staff had, had an appraisal. An appraisal matrix had been formulated to capture these in 2017 which was shown to the inspectors. The current management team had recognised the lack of appraisals and put in place a plan to carry these out as well as supervisions.

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

We checked people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support.

In people's care records we saw entries of involvement from other professionals with people's care, including doctors, specialist nurses, opticians and dentists. This showed people were supported with their health needs where required.

We saw in people's care files that people received involvement from external health care professionals, such as the GP, district nurse, dietician and speech and language team at times when they required this.

We also observed a medic was called for a person who had become unwell.

A relative told us they had raised concerns about the medicines their relative was prescribed, because it had made them drowsy and the doctor had therefore reduced the dosage. This showed people using the service received additional support when required for meeting their care and support needs.

Another family told us of the involvement of the tissue viability nurse for their relative, because of a pressure ulcer their relative had.

We checked how people's individual needs were met by the adaptation, design and decoration of the service and found improvements were ongoing in accordance with the service's action plan to improve the design and decoration of the service. However, we found whilst the service had addressed locks on communal toilet doors, there was a broken tap in one of the toilets making it unusable and presenting a risk to infection control.

We also saw in one bedroom the person's bedroom curtains were ill fitting. This lack of attention to detail showed a lack of care for people's living environment.

Is the service caring?

Our findings

We saw in the main, people had clean and manicured nails, looked well groomed and clean, showing they had received support with personal care. However, a relative told us "I've just called in to check on [relative] and they're wet. Their feet are as black as coal underneath and they're trying to get off the bed and can't. I know they are busy, but if you don't keep on top of them the standards slip. I know [relative] won't keep their slippers on and I know they will change them, but I feel as if I've got to keep pushing and pushing them all the time." We saw after this that staff did wash the person's feet, but within half an hour these were dirty again. Staff told us it was because they refused to wear footwear. On arrival on the second day of inspection the same person's feet were as dirty as on the first day.

Another family told us they were happy with the care provided and said "In general some staff are excellent, some are good and some not so good, but we have a whiteboard on the bedroom wall and we write on there if we have any axes to grind. We've no complaints in general about staff. The place is kept clean and all in all we are alright, we've no complaints. The night staff are not so good, but in the day time there are some good nurses. If you've any complaints they deal with it - we get on well with staff."

Staff we spoke with were able to describe how they maintained people's dignity and respect and gave examples of how they would implement this. This included practice such as ensuring personal care was provided discreetly and maintaining confidentiality. One staff member commented, "We care about this work. We aren't in this for the money after all. There's real passion here."

Throughout the inspection we saw staff interacted with people in a friendly, caring and professional manner. In general, relationships looked easy and friendly. For example, we saw one member of staff explaining to the nurse that they had tried to encourage the person they were sitting with to move to a bigger chair, but they refused, so they continued to read to them where they were. In discussion with the member of staff we found they were familiar with people's likes and dislikes and spoke fondly of them.

On another occasion we saw a member of staff sat with someone talking about Charlie Chaplin. The person was enjoying the conversation and was very talkative.

We heard two staff encouraging one person to rise, who was reluctant to do so. We heard the staff being patient and calm. We also heard when staff changed their role during the day, they provided a handover to the staff member taking on their role, discussing the person's mood and what had worked well with them that morning.

On another occasion we heard a person saying they were a burden and a member of staff was patiently reassuring them that this was not the case.

We saw staff knocking on bedroom doors before they entered, demonstrating respect for people.

We saw staff use touch and sit at the side of people or bend down to crouch at the same level whilst

supporting and talking to them. Most people appeared content and we consistently saw staff were patient with people and gave them repeated reassurance. Staff did not rush people in the conversation they were participating in.

We did not see or hear staff discussing any personal information openly or compromising people's confidentiality.

We saw information on display in the reception area about how an advocate could be accessed in the event a person needed this service. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

Is the service responsive?

Our findings

We checked people received personalised care that was responsive to their needs.

We looked at three people's care records. People's care records and other related documentation were not always accurate or up to date and it was not easy to find information about people. For example, one person's care plan identified they required their position changing every two hours because of a pressure ulcer. Discussions with staff on the first day of inspection identified the pressure ulcer had healed and the person was now on four hourly position changes to mitigate the risk of further pressure damage. The care plan had not been amended to reflect this, although the position chart used to record when the person was repositioned confirmed what staff had told us. On the second day we checked to see that the care plan had been updated. Staff told us position changes to two hourly had been reinstated as the person's skin integrity had deteriorated. This meant without discussions with staff, professionals viewing the care plan and repositioning records would find conflicting information about how the person's care needs at that time and over time information that the repositioning for a time every four hours was not known.

For the same person their mobility care plan had not been updated to reflect their current needs in that they were no longer independently mobile. Although staff had recorded the changes within the evaluation section, the plan had not been updated to identify what this meant in terms of caring for the person. For this person, staff told us they were being cared for in bed because there was not an appropriate chair for them to sit in and a referral had been made to the physiotherapist team. We looked at those referrals and none identified this as the reason for the referral. This meant the person had remained in bed for two months. We raised this on the first day of inspection and action had still not been taken on the second visit three weeks later. A member of staff said, "[Person] does listen and look around so would benefit from sitting in communal areas."

For two people their eating and drinking care plan, did not contain information from speech and language professionals about the rationale for their diet.

When we spoke with senior staff to verify or not information in care plans they did not take ownership and responsibility about the information saying, "It's a decision that's been made whilst I wasn't here."

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw people were provided with greater stimulation than on our previous visits. For example, we saw an old film on the television, which had been put on for the benefit of people and some people were watching it.

We spoke with the activities co-ordinator who was familiar with people and their likes and dislikes. For example, they told us faith was important to one person and they liked them to read a prayer book to them, which was appreciated by their family. They told us their priest visited. This was confirmed by a family

member when we spoke with them and they said this was very important to their relative.

The activities co-ordinator told us another person used to be a footballer so they enjoyed using a beach ball for exercise.

Other activities the activity co-ordinator told us they engaged people in were baking, art therapy, board games, exercises and reminiscing. At the time of the inspection the activities co-ordinator was working on a wedding board and had written to relatives requesting photographs of people to put on display.

We saw throughout the day the activity co-ordinator and other staff engaged in spells of individual meaningful activity.

We checked how the service listened and learnt from people's experiences, concerns and complaints.

We found where people had raised concerns, these had been listened and responded to. However, we found the actions taken to prevent a reoccurrence were not always recorded and there was not always supporting evidence of the root cause of how something happened, before best interest decisions.

There was no analysis of complaints, which meant the service did not have a system in place to identify numbers and themes to aid them in making improvements at the service.

We saw a complaints policy/procedure was in the reception area for visitors to identify how they might make a complaint.

Is the service well-led?

Our findings

We checked the service demonstrated good management and leadership, and delivered high quality care, by promoting a positive culture that was person-centred, open, inclusive and empowering.

The most recent rating of the registered provider was not displayed in accordance with guidance provided by the Commission to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 on the website. The rating on the website was rectified immediately after the inspection.

The manager provided the statement of purpose that had been reviewed on 2 August 2016. This contained out of date information, but was updated during the inspection. The registered providers address in the statement of purpose and certificate of registration did not correlate to that held on Companies House. This was identified to managers at the end of the inspection to address as it mean there was information that did not tally about the registered office address of the registered provider.

The service continued not to have a registered manager. The service had appointed a new manager since the last inspection, meaning there was still a lack of continuity in the management and leadership of the service. The new manager had commenced employment in October 2016 and told us they had submitted their application. There was no record of this at the Commission. This meant the registered provider was in breach of a condition of their registration, which requires them to have a registered manager at the location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Since the last inspection the whole management team responsible for the service had changed. The new management team had commenced in October 2016. This meant there had been three different management teams in place since February 2016. Discussions with the current management team confirmed their intention to drive improvement at the service and achieve stability.

When we asked relatives about the management and leadership of the service one relative commented, "We have had a lot of managers in the last two years, but since this new manager came the staff are a lot happier."

General observation of the management of Parklands care home was that the manager, regional and regional support managers were visible and involved with the day to day running of the home. The manager told us she felt supported by her managers and that meetings had taken place with the local authority to discuss what support they could offer and what support they required to make improvements.

Staff's views of management identified they were visible in the home and were supportive. Comments included, "We're working well as a team. [Manager] has some good ideas", "The manager has not been here very long and I can't go to [staff member] because she is condescending and speaks down to me, so I

choose not to go to them. I feel if I pass on my view they wouldn't be taken seriously or listened to and put right. Manager has her hands full with more important issues" and "I feel well supported. New manager is lovely and is definitely making a difference. She knows what she's doing."

Prior to our inspection we spoke with the contracts department of the local authority. They told us they were supporting the registered provider to make the necessary improvements to provide a quality service including, but not exclusive to, training, record keeping, demonstrating compliance with the principles of the MCA, care plans and risk assessments, medicine management and infection control. Other stakeholders such as doctors and community nursing were also being asked what support they could offer. The registered provider had agreed to a voluntary embargo on all admissions since November 2015. This meant they were not admitting any new people.

We viewed the infection control audit carried out by Barnsley Metropolitan Borough Council as part of their assistance. It highlighted a compliance rate of 78%, with percentage scores of 39% in governance and documentary evidence, 55% in hand hygiene and 40% in respiratory care. This meant improvements were required to meet infection and control standards.

There was a schedule in place to check the quality of the service provided including monthly audits for medicines, care plans, daily charts, finances and monitoring visits and bi-monthly audits of the environment, staff files and kitchen. We found there had been gaps when those audits had not taken place.

The service formulated actions required from each of the audits to monitor ongoing improvements, with timescales. These were ineffective in practice, because we found these had not always been addressed in the timescales required and remained requiring improvement and we identified similar improvements during the inspection.

There was no analysis of complaints, which meant the service did not have a system in place to identify numbers and themes to aid them in making improvements at the service. Likewise, for incidents and accidents.

A regional manager also conducted audits on behalf of the registered provider. They told us that monthly audits of MUST, MCA and tissue viability were not yet in place and were to commence in March 2017. The last two audits identified a score of 51% and 53%. This showed the registered provider had identified the service required improvement, areas for improvement and actions required, but slow progress was being made in raising standards and provide a quality service that met regulations.

Our findings from this inspection identified the governance systems in place to evaluate and improve practice and to meet breaches of regulation had not been effective and the service remained in breach of regulations in regard to person-centred care, need for consent, safe care and treatment, good governance, staffing and fit and proper persons employed.

This meant the service was not meeting the requirements of the regulations in regard to good governance and was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us staff meetings took place, which meant staff were provided with an opportunity to share their views about the care provided. Records showed that at staff meetings, staff discussions included topics such as infection control, moving people, meal times, care plans, training, the roles of staff and laundry.

We also found a staff questionnaire had been sent to staff in January 2017. On the second day of inspection this had been collated. There was a return rate of 30%. The analysis was contradictory stating in one area there was a reasonable response rate and in another 'quite low' and the survey was quite positive, despite a number of areas in regard to staff recognition and feeling that the organisation would not address their concerns scoring low. Comments included, "I do want to do my best and work and try my hardest, although I do feel with some staff that I carry them through the shift, I'm left to pick up the work left", "I do feel I do my job correctly, but I think we could need other equipment to help staff do this to the highest standard for the residents" and "Due to the amount of work on day shifts, I feel like we don't get enough time to comfort or care in the way I want to". An action plan to initiate improvement had been formulated.

We found quarterly resident and relative meeting dates had been identified and were displayed. We also saw relatives had been provided with an opportunity to feedback their opinions of the quality of service provided since the last inspection via a relative questionnaire conducted in October 2016 and a report collated in November 2016. Eleven relatives responded to the survey. The overall rating was identified as 36% rated the service as excellent, 55% as good and 9% as fair. Actions identified from the report were broad and included more choice for soft food options, address laundry and review complaints process.

The home had policies and procedures in place which covered all aspects of the service. Some policies and procedures required review to meet current legislation and practice.

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 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Care and treatment of service users was not always appropriate to meet their needs and reflect their preferences.

The enforcement action we took:

Remove the location from the registered provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	Care and treatment of service users was not always provided with the consent of the relevant person.

The enforcement action we took:

Remove the location from the registered provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment was not always provided in a safe way for service users.

The enforcement action we took:

Remove the location from the registered provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not always established or operating effectively to comply with the requirements of the regulations.

The enforcement action we took:

Remove the location from the registered provider's registration.

Regulated activity	Regulation
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Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed

The registered person could not always assure themselves persons employed for the purposes of carrying on a regulated activity must be of good character, have the qualifications, competence, skills and experience which are necessary for the work to be performed by them and be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed. This was because recruitment procedures were not operating effectively to ensure that persons employed meet the conditions above and that information specified in Schedule 3 was available in relation to each person employed.

The enforcement action we took:

Remove the location from the registered provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of the regulations. Persons employed by the service provider in the provision of the regulated activity must receive such support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

The enforcement action we took:

Removal of the location from the registered provider's registration.