Parkgate Manor

Parkgate Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Parkgate Manor provides accommodation and personal care for up to 40 people who have learning disabilities. Some people had specialist needs associated with downs syndrome, mobility or special diets. Some people communicated verbally, and others used gestures and body language to make their needs known. The majority of people were under 65 years of age. There were 31 people living at the service when we visited. Accommodation was on ground and first floors.

There had been two changes to management since our last inspection. Quality and governance systems had not been fully kept up to date. A new manager was appointed in February 2021. They were aware that there were areas particularly in relation to record keeping that needed improvement. Systems were being established to ensure care plans were updated, to ensure greater analysis was carried out in relation to welfare checks, records held in relation to daily records, and activities. There was limited oversight of some people's mealtime experience to ensure support was always person centred. Some incidents of potential abuse had not been reported to the Commission as is required.

The service was clean and tidy throughout. Enhanced cleaning had been instigated as a result of the pandemic, staff had received additional training and the service had a visiting procedure that complied with government guidance. The measures taken ensured people were protected, as far as possible, from the risk of COVID-19.

People were protected from the risks of harm, abuse or discrimination because staff knew how to recognise and respond to any possible abuse. There were enough staff working and available to provide safe support for people. Recruitment practice was thorough and ensured only suitable staff worked at the service. There were suitable arrangements to respond to any risk to people and to provide people with their prescribed medicines.

The new manager had established a positive culture at the service and was working closely with staff to ensure people were supported appropriately and safely. They understood their responsibilities and were making positive changes in the service to improve systems and outcomes for people. There was a clear management structure and staff knew their individual roles and responsibilities.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or

autistic people.

The service was able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture and work was continuing to ensure care was always provided in a person centred way.

Right support:
• The model of care and the layout of the setting had been developed to ensure people had a choice in where to spend their time. There was a large dining room and a separate sun lounge and two other lounge areas. In addition, there were very large grounds/gardens and some people chose to spend time outside daily. There was an ongoing programme of redecoration and improvements had been made to the toilet areas. Guidance in care plans was being updated to ensure they included more detailed advice on how to meet people's individual needs and wishes.

Right care:
• The service tried to ensure people received support from staff who knew them well as individuals. Where agency staff were used, they were staff who had worked at the service regularly and knew people well. Improvements were being made to ensure that care was more person-centred but further work was required to fully achieve this.

Right culture:
• Some people attended day centres throughout the week. Staff supported others to take part in activities of their choice to meet their individual needs and wishes. This included meals out, walks on the seafront, arts and crafts at Parkgate and gardening projects. Those that were able, were encouraged to participate in activities of daily living such as folding their own laundry, clearing the table or emptying bins. The home was actively recruiting for a new activity coordinator so there were not as many activities provided as there would normally have been. People were supported to maintain contact with their families and friends.

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

Rating at last inspection (and update)
The last rating for this service was requires improvement. (published 12 July 2019). There were no breaches at that time. Since then an infection prevent and control (IPC) assurance inspection was carried out on 4 March 2021 and the provider was found to be in breach of regulation. The provider completed an action plan after the inspection to show what they would do and by when to improve. At this inspection we found improvements had been made to IPC and the provider was no longer in breach of that regulation. However, the service remains requires improvement and we found breaches of regulations 17 and 18. This is the second time the service has been rated requires improvement.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe, caring, responsive and well led.

The ratings from the previous comprehensive inspection for the key question not looked at on this occasion was used in calculating the overall rating at this inspection. The overall rating for the service has remained the same. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for

Parkgate Manor on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for 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 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?

Good

The service was safe.

Details are in our safe findings below.

Is the service caring?

Good

The service was 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.

Details are in our well-Led findings below.

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 Care Act 2014.

This focussed inspection was prompted by our internal intelligence systems that assess potential risks at services.

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

Inspection team
The inspection team consisted of two inspectors.

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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager, but they were not registered with the Care Quality Commission. This means the provider alone is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
The provider was not 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 reviewed the information we held about the service and the service provider, including the previous inspection report. We looked at notifications 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. We used all of this information to plan our inspection.

During the inspection
Some people were not able to share their views of the service due to their complex communication and support needs. Therefore, we observed their experiences living at Parkgate Manor and staff interactions with them. We spoke with the manager, the managing director, head of care and three staff members.

We reviewed a range of records. This included four people's care records in full, aspects of other care plans and everyone's medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, health and safety files and policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas, some training records and quality assurance records. We received feedback from four people's relatives and five health and social care professionals.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last comprehensive inspection this key question was rated as good. Since then an infection prevention and control assurance (IPC) inspection was carried out to look specifically at IPC measures. At that inspection we found a breach of regulation. We did not assess the rating at that inspection. At this inspection this key question has now remained the same and the provider has met the breach of regulation.

This meant people were safe and protected from avoidable harm.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections. All visitors were asked to complete a test before they visited the home and were asked to wear PPE whilst on the premises.

● We were assured that the provider was meeting shielding and social distancing rules. The home has several communal areas and large grounds. People were encouraged to keep social distance and when they had an outbreak, people were cared for in their own rooms.

● We were assured that the provider was admitting people safely to the service. The home followed government guidance for all new people admitted to the service.

● We were assured that the provider was using PPE effectively and safely. The home's day centre was used by staff for donning PPE on arrival to the service. There was a plentiful supply of PPE and staff were seen to wear PPE appropriately.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. Following our last inspection some of the toilets were altered in terms of layout to improve hygiene practices. These areas were due to be refurbished in line with the home's action plan.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. All staff had received training on IPC. An IPC audit had yet to be carried out, but cleaning schedules were used to record all the cleaning carried out and the managing director met with cleaning staff daily to monitor this. Following our inspection, we received a detailed IPC audit.

● We were assured that the provider's infection prevention and control policy was up to date. Since our last inspection the IPC policy had been updated and was now much more detailed.

● We were assured the provider was facilitating visits for people living in the home in accordance with the

current guidance. All visits were carried out either in the garden or in the day centre on site. Relatives told us they felt secure with the arrangements to prevent infections.

Using medicines safely

● There were safe procedures to ensure medicines were correctly ordered, stored, given and recorded appropriately. The home's policy was that only trained senior staff had responsibility for supporting people with medicines.

● Some people took medicines on an 'as and when required' basis (PRN) for example, for pain relief. There were protocols in use that described when they should be used, but these lacked detailed information about the criteria to consider before giving them. The manager had already identified this as an area for improvement and had been in touch with the local medicines optimisation in care homes (MOCH) team for advice and guidance.

● A new system had been introduced that at each medicine round, a stock count was taken. On the day of inspection some discrepancies were noted by staff and they carried out an assessment to determine the shortfalls. The new system worked well and meant that any problems would be identified quickly.

● There was very detailed information to guide staff on how each person liked to receive their medicines. For example, some liked to take their medicines in their hand, others took them with food.

● Staff had received online training in the management of medicines. In addition, they were assessed in terms of competency before they were able to give medicines.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe. Some were not able to tell us, 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, "(Name) tells me he is happy, and he is doing the things he does that shows me he is happy." Another told us, "My general impression is that Parkgate Manor is a good place." A third said, "They have contacted us when (name) was ill or if there are any issues. They know we are interested and want to be kept informed."

● Staff had a good understanding of how to make sure people were protected from harm or abuse. A staff member told us, "When situations escalate, people generally respond to negotiation and distraction."

● All staff had received safeguarding training and knew how to recognise signs of abuse.

Assessing risk, safety monitoring and management

● Risks to people were well managed. There were behavioural support plans to guide staff in supporting people who may express emotional distress. Some plans were written with support from the local community learning disability team. A health professional told us they had, "No concerns about patient safety."

● Where risks were identified, there were appropriate risk assessments and risk management plans. These helped people to stay safe while their independence was promoted as much as possible. For example, if someone had an increased risk of falls, a risk assessment was carried out to determine if there were any safety measures that could be taken to reduce the risk of injuries, for example having a crash mat by the bed or ensuring footwear was secure.

● Risks in relation to people's skin integrity and the prevention of pressure sores had been assessed. If someone had an air flow mattress there was daily monitoring to make sure it was set at the correct setting.

● 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. New fire escapes had been fitted since the last inspection. Fire drills were held regularly to ensure staff and people knew what to do in the event of

a fire.
● People lived in a safe environment because the service had good systems to carry out regular health and safety checks including checks on gas and electrical appliances safety. Water temperatures were monitored regularly and a check on Legionella had been carried out.
● Maintenance checks were carried out and where shortfalls were identified they were put on a maintenance plan. There was an action plan of all work to be completed, by whom and with timescales. We saw that arrangements had been made to have some windows replaced and to have new flooring replaced in some bedrooms and bathrooms.

Staffing and recruitment
● There were enough staff to meet people's needs safely. Annual leave and staff sickness hours were covered through bank staff and regular agency workers.
● There were three waking staff members at night-time. 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.
● 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 had been carried out for all staff to help ensure staff were safe to work with adults in a care setting.

Learning lessons when things go wrong
● There was evidence that lessons were learned when things went wrong or when procedures needed to be changed. One person had a known medical problem that required an almost monthly emergency admission to hospital. A system was set up to ensure the person could be admitted directly to the ward rather than having to go through the hospital triage system and this meant treatment could be provided swiftly.
● One person was given a meal that was not in line with their specialist diet. Support was sought immediately, and the person came to no harm. Whilst information in the person's support plan was detailed and staff could tell us how to support the person safely, specialist training was also being set up for all staff on how to safely support the person with their dietary needs.

Good

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 the last inspection this key question was rated as requires improvement. This related to a lack of staff interaction with some people and a lack of guidance in care plans regarding how people expressed their sexuality. At this inspection this key question has now improved.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were supported by staff who knew them well. Staff were caring in their approach and they checked regularly with everyone to make sure they were meeting their needs and wishes.
- Staff told us about people's needs, choices, personal histories and interests. They knew what people liked doing and how they liked to be supported.
- Staff communicated well with people and in a way, they could understand; people responded warmly to them by smiling and showing they understood what was said to them.
- A health professional told us, "I find the team very friendly, engaging and certainly supportive and caring for the residents and their needs." Another told us, "Staff seem to be caring and to know their residents well, and their support needs."
- There were several dining tables in the dining room and in the sun lounge so people could choose where and whom to sit with. Tables were presented well with individual wipeable placemats and each table had a plant for decoration. New sofas had also been bought for the lounges, so people had a choice of armchairs, two-seater and three-seater sofas to sit in.

Supporting people to express their views and be involved in making decisions about their care

- A staff member told us, "People make decisions about the clothes they wear daily. We give them lots of different options. If they don't want a shower or bath, we tell them we can do it later. (Name) never wants a bath or shower, but they have a good wash and we are able to wash their hair. (Name) is happy with that."
- Staff told us that a new hairdresser had recently started to come to the service, and they were gradually getting around to everyone's hair. Two people had recently expressed a wish to go to a barber and this had been supported. Staff had discussed with them what they had wanted done. One person had chosen a hairstyle that was very different to what they had. Staff told us the person was, "Over the moon with his new hairstyle, he loves it and it really suits him."
- We were told that when people's rooms were redecorated, they chose the colour of their rooms. Bedrooms reflected people's individual tastes and preferences.

Respecting and promoting people's privacy, dignity and independence

- Respect for privacy and dignity was at the heart of how the home operated. A staff member told us, "If a person refuses care, we always make sure that another staff member offers this support later. The person

might not have wanted the first staff member or might not have been ready to receive care when they were asked first."

● They also told us, "We always make sure people wear a dressing gown to walk from the shower to their bedroom." Another staff member told us, "We always knock before entering a person's room." We saw staff do this during our inspection.

● One person's needs had changed so with staff support; they had moved to a room on the ground floor.

● A health professional told us that during the vaccination process, "Staff at Parkgate were engaging not only with them, but the residents and family as well. The level of care and understanding shown by the staff during this difficult time was outstanding to their residents, and the encouragement and support whilst they were being vaccinated showed a deep level of understanding for their residents and their individual needs."

● People were encouraged to be independent in various ways, such as helping with the bins, folding laundry, gardening and clearing away dishes. Care plans included advice about encouraging people to be more independent with aspects of their personal care and if people needed encouragement to participate in tasks this was recorded.

● One person liked to spend a lot of time in the garden daily and this wish was respected.

● We observed staff supporting people to move safely from their wheelchairs to dining chairs. Staff explained what they were doing and provided reassurance. Support was provided safely and with dignity.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. This was because some care plans had generic advice on how to support people when they were distressed. There were concerns about the availability of drinks for those who could not communicate their needs outside of drinks round times. Whilst these specific areas were met at this inspection this key question has now remained the same.

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

- Care provided was not always person centred. The home was in the process of reassessing all care plans to make sure they were up to date and included person centred information. The head of care was working with people and staff who knew people well to make sure care plans included key information.
- Support with meals was not always provided in a person-centred way. The majority of people ate their meals in the main dining room. Five people ate their meals in the sun lounge. Everyone was given their main meal, dessert a cold drink and a hot drink all at once. The manager was not aware this was happening. This had been done when meals were taken to people's bedrooms when the home had an outbreak. The manager confirmed this practice would cease immediately.
- One person's care plan stated they should be encouraged to complete their main meal before dessert was offered, however as they had both at the same time they moved on to dessert and there was no prompting to complete their meal. Another person's guidelines stated they should be observed having their meal and encouraged to eat slowly. The person was seated facing away from staff, so they were not observed.
- As one person was assisted with their meal, another person kept interrupting the meal as they tried to get the attention of the staff member. The staff member told the person they would attend to them when they had finished supporting the person with their meal, but this did not satisfy them. Eventually another staff member took over and the person was able to have the rest of their meal uninterrupted.
- One person's care plan clearly stated the person could become agitated if people invaded their space. This person had particular sequences of activities that they needed to follow and if anyone tried to interrupt this process this could lead to them becoming anxious. Whilst the care plan included some advice, it lacked specific detail that a new staff member or agency staff member would need to know.

The above issues were discussed with the manager as areas for improvement.

Despite the above observations we also saw examples of very good person-centred care.

- One person required emergency hospital treatment on an almost monthly basis. Working with various professionals, the person's medicines were reduced, this led to improvements in their mental health which in turn meant staff could support the person to be more active. This had positive impact on the person's health and wellbeing and hospital visits had been reduced significantly from monthly to two to three times a year. The manager told us the whole process took almost a year of working jointly with the various

professionals.
● A health professional told us, "I've been really impressed with the kindness of the current placement staff. They (particularly manager) are always responsive and push for things to happen.
● Another health professional told us, "I have seen evidence of skilled carer support, understanding of maintaining independence skills in eating and drinking, and seeking the least restrictive diets for residents, whilst balancing that with reducing the risks involved if guidelines aren't strictly adhered to."
● A staff member told us that one person had one to one support. They said, "One day (name) will do everything for themselves but the next day they might need full support, this is due to their dementia and we have to adapt and give support dependent on how they are."
● The home monitored that people had enough to drink and where there were concerns, fluid charts were kept. We saw that people were offered and received regular drinks throughout our inspection.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Staff knew people well and how they communicated. Each person had their communication needs assessed and recorded.
● Some people were able to communicate their needs and wishes verbally. Others used a variety of communication methods and tools and staff were skilled in understanding these. A couple of people used Makaton, a form of sign language, to assist the spoken word. Others used pictures to aid their communication. The manager told us training had been set up for staff on Makaton, but this was then cancelled due to the pandemic and would be rearranged. They also said they used to have a 'sign of the day' and would look to reinstate this.
● There were easy read versions of the complaint procedures and other important information that was displayed. Staff told us some people responded well to these, others preferred information to be relayed to them verbally. Menus were displayed and we saw that staff encouraged people to make choices of food. People were also encouraged to wear glasses and hearing aids if they needed them.

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
● People were supported to maintain contact with people who were important to them. One person was in a relationship with someone who lived in a different care setting. They were supported to have regular video calls and arrangements were in place to support visits.
● Whilst some people had relatives that lived locally, staff told us that a number of people either had no relatives or did not have relatives who lived close by. They told people went out in the minibus for drives, for walks along the beach or lunch out. We saw that some people were also supported to take walks in the grounds.
● The manager told us the activity coordinator had left their position and they would be advertising for a replacement. Staff told us that they did arts and crafts sessions and baking sessions with people. The managing director brought her dog in and one person particularly looked forward to these visits. A staff member told us, sometimes we play football outside and we have a games cupboard which people enjoy.
● People told us they spoke with relatives by phone or video calls and relatives confirmed this.
Relatives told us staff remained in touch throughout the pandemic and they were confident that if there were any concerns about loved ones, staff would be in touch.
● Staff told us that when one person could not attend their day activities during the pandemic, they

encouraged them to spend more time in the garden, planting flowers and helping with folding laundry. The person had thoroughly enjoyed having positive activities to keep them busy. Two people went out for day activities three days a week.

● One person's care plan stated that when they were anxious, they should be supported to do tasks such as emptying the bins as this was something they liked to do. We saw staff supporting the person with this task.

Improving care quality in response to complaints or concerns

● There was a detailed complaints procedure and an easy read version that was displayed for people.

● There were two complaints recorded, one from staff and one from a person living at Parkgate Manor. This showed the person felt confident of using the complaints procedure. They had complained about the support received by an agency worker, this was addressed immediately with the agency and the worker no longer worked at the service. Both complaints had been appropriately recorded, investigated and resolved.

End of life care and support

● Whilst staff followed advice and guidance from the local hospice at home team, very few of the staff had completed end of life training. The head of care told us this was an area they had a particular interest in, and they would provide training for staff.

● Where appropriate, some people had a Recommended Summary Plan for Emergency Care and Treatment (RESPECT) form completed. These plans provide a wide range of information about the person's wishes in the event of an emergency but also in relation to end of life care. For example, we saw one person did not want to be resuscitated but if the cause of illness could be treated, then they wanted to receive this support.

● The manager and staff worked with the local hospice to ensure people could remain at the service at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. At the time of our inspection, one person was in receipt of end of life care. This person had no family so staff took it in turn to be with the person until their death.

● Staff had spoken with each person about their wishes in relation to funerals and they had made a range of choices such as whether to have a religious service, the type of music to be played and if they wanted flowers. Where someone was unable to contribute to this process then family members were consulted for their opinions.

● Within the grounds, an area was set aside as a memorial garden, known as the 'forget me not' garden. This area had been 'blessed', and some people had chosen to have their ashes scattered in this garden when they died. The manager told us that one person had recently been speaking negatively about death, so they supported him to plant a tree for one of the past residents on the anniversary of her birthday. This had helped to reduce the negative thoughts.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

● Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Since our last inspection there had been two changes in registered manager. The last registered manager left their position on 26 February 2021. A new manager had been appointed and had recently submitted their application for registration.
● Although there were systems to monitor the running of the service, some were not effective. During the pandemic the home had suffered 'outbreaks' so as a result they had not managed to keep up with some of the quality assurance systems. The manager was aware there was a lot of work required to improve record keeping. The process of updating care plans had started. There was a lack of detail in daily records. Records were about tasks rather than care and support offered, choices made, how people were, and the activities they took part in.
● There was a lack of oversight of the mealtime experience which meant that the care provided was not always person centred. Welfare checks were carried out to determine how may falls had occurred, how many people had urine infections or bruises etc, but there was limited analysis of the findings and records did not always show what action was taken or if action taken was effective.
● Incidents were recorded but sometimes the wording used was not clear and could be open to misinterpretation. Following some, an antecedent, behaviour and consequence (ABC) chart was completed but this was not always done. ABC charts are used to assess what may have led to the incident, how it was managed and how it was resolved. There was limited analysis to determine if people's guidelines had been followed and if they had been effective.
● Whilst fire drills were held regularly, there was no record of the staff in attendance and drills were not fully evaluated.
● Systems for seeking the views of people, relatives and professionals on the running of the service had not been carried out.
● Staff surveys had been carried out. However, this had shown a low staff morale, staff working long hours, lack of understanding of job roles and responsibilities and staff wanting more supervisions and meetings. We saw through minutes of a staff meeting that roles and responsibilities had been clarified, and that team building exercises had been started. Staff told us they felt supported. The manager agreed it would be useful to repeat the survey to check if the improvements made had been sustained.
● The management team met regularly, and a seniors' staff meeting had been held recently, however, the

last staff meeting was held in September 2020. The manager was aware they needed to arrange a meeting for day and night staff to hear their views on the running of the home.

The failure to operate effective systems and processed to assess and monitor the service is a breach of Regulation 17 of the Health & 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

● The manager understood their role and responsibilities to notify CQC about certain events and incidents and these had been submitted promptly. However, there were also several allegations of potential abuse that had been reported to the local authority for possible investigation under safeguarding, but these had not been reported to the Commission. None of the matters reported had been accepted by safeguarding and they had been logged as 'information only'. However, providers are required to notify CQC of any allegation of abuse without delay and this had not happened.

The failure to report abuse or allegations of abuse, without delay, is a breach of Regulation 18 of the Health and Social Care Act Registration Regulations 2009.

● A social care professional told us, "They (home) take a thorough approach to looking at what has gone wrong, how to approach reducing risk and ensuring they speak to the adults concerned regarding what has happened and what people would like to happen. We find them a responsive service, transparent with good communication."

● The manager was open and knowledgeable about the service, the needs of the people living there and where improvements were required. This was demonstrated through the inspection process, they offered additional information to clarify and support inspection findings.

● The 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 when untoward events occurred.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● Staff told us they felt very well supported. A staff member told us, "Both the manager and managing director are very easy to talk with, I am clear about who I need to go to for support. Roles and responsibilities are divided up and everyone is clear about who has responsibility in each area."

● A staff member told us they felt very well supported by the management team. They said, "We are shown appreciation, you don't get that in a lot of places, we are always thanked for what we do. We have a great team"

● Another staff member told us, "The managers and seniors are amazing. They could tell I was nervous when I started and they told me to feel free to ask questions no matter how silly, they were there for me."

Working in partnership with others: Continuous learning and improving care

● Referrals had been made for specialist advice and support when needed. People continued to receive chiropody treatment and where appropriate support from the speech and language therapy team, physiotherapy, the bladder and bowel team, guys hospital and the community nursing team.

● The home received a weekly phone call from their GP, and they had support from the medicine's optimisation team. These enabled health reviews to be done and were an opportunity to monitor people's medicines and answer any queries they had.

● A health professional told us, "The team has been keen to learn, and implement my plans carefully and fully. I've enjoyed working with them."

● Another health professional told us that during the pandemic when face to face visits were not allowed, Parkgate's internet connection was not good enough to enable video links to carry out remote assessments. This caused some delay in assessments being carried out but did not have any serious impact for anyone. They told us, "On the whole I am happy with my working relationship with Parkgate Manor and feel they provide good care for residents in terms of their willingness to involve (professionals)."
● A third professional told us the home had been able to "Facilitate video calls, so that I can speak with and observe my clients. Any health concerns have been dealt with quickly and the head of care will always call me between visits if there are any concerns." We spoke with the manager and managing director and they confirmed the internet connection could be inconsistent.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to report all allegations of abuse. 18(1)(2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not assured appropriate systems and processes were in place to fully assess, monitor and improve the quality and safety of the service provided. 17(1)(2)(a)(b)(c)(e)