HC-One Oval Limited

Mersey Parks Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Mersey Parks Care Home is a residential care and nursing home providing personal and nursing care to 99 people aged 65 and over at the time of the inspection. The service can support up to 120 people. The care home is set across four separate single floor units and an office block. One unit provides nursing care, two units provide residential care for people living with dementia and the fourth unit provides residential care. Each unit comprises of various communal areas, including living and dining areas and adapted bathrooms, and single bedrooms with ensuite facilities.

People's experience of using this service and what we found
Since our last inspection the provider had made limited progress in addressing the concerns found. Although they had appointed a new manager, measures had not been implemented in an effective and robust manner or evaluated to ensure they were effective in driving improvement. We found continued and new breaches of regulation during this inspection. People and relatives generally spoke positively about the staff and care provided but had mixed feedback about communication from the service.

We found that there were not always enough staff to meet people's needs in a timely way. People's prescribed creams were not always securely stored in line with best practice. Individual and environmental risk assessments were in place, but these were not always detailed or accessible to help staff reduce risk as much as possible. Health and safety checks were completed but did not identify shortfalls such as damaged furniture, which we found during the inspection. People were supported when they had been involved in accidents or incidents. However, it was not always clear that lessons had be learnt and sufficient steps had been taken to reduce future risk.

People's needs were assessed, and referrals made to health care services when needed. Care plans were not always updated to clearly reflect people's changing needs. People had care plans in relation to eating and drinking but we observed that staff were not always able to provide the support and encouragement that people needed to eat and drink enough. Not all staff had up to date training or regular supervision, but the new manager was working to address this. Records did not always demonstrate how people were supported to have maximum choice and control of their lives. We observed staff supported people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice but were not always robustly applied.

Rating at last inspection
The last rating for this service was requires improvement (published 9 August 2019) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made or sustained and the provider was still in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections under this provider.

Why we inspected
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We received concerns in relation to staffing, training, and management oversight. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-Led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has remained Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective and Well Led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

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

We have identified breaches in relation to the planning and delivery of individualised care; the management of risk; the management and suitability of the environment and equipment; the arrangements for oversight to ensure good care is delivered and drive improvement; and staffing levels, and training and support provided to staff.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Mersey Parks Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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 an Inspection Manager, two Inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Mersey Parks Care Home 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.

At the time of the inspection the service did not have a manager registered with the Care Quality Commission. There was a home manager who had recently started in the post and intended to register with the CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This 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 all the information we held about the service including statutory notifications the service has sent and feedback we had received. We contacted the local authority for additional information and feedback. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with fourteen members of staff including the manager, deputy manager, unit manager, care workers, and domiciliary staff including the chef and housekeeping staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the service's staffing levels and walked around two of the units to ensure they were clean and a safe place for people to live.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

The Expert by Experience made telephone calls following the site visit and spoke with two people using the service and seven relatives.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, maintenance records and other information the service sent to. We contacted staff to obtain further feedback about their experience of working at Mersey Parks Care Home and spoke with other people who had contacted us regarding the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

At our last inspection the provider had not always ensured the effective deployment of appropriate staffing levels to maintain people's safety, dignity and other fundamental care standards. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were systems in place to assess people's level of need and staffing requirements. However, our observations were that there were not enough staff and that people did not always receive the support they needed in a timely way. We discussed our observations with the manager on the day who advised the dependencies in the unit will be reviewed to ensure that the staffing reflects dependency.
● Staff were very busy throughout the day. Staff told us they did not feel there was enough staff to meet people's needs and some felt anxious that they were unable to provide quality of care they wanted. Relatives had mixed views on staffing levels with one relative telling us, "I feel there are enough staff, they can be overstretched sometimes but they always have time to talk to me." whilst another relative told us, "I have been worried about a lack of staff."

The provider had failed to implement systems that were robust enough to ensure appropriate staffing levels were in place to meet people's needs in a timely way. This placed people at risk of harm. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were safe systems for staff recruitment in place. Staff files contained the necessary checks and documents to ensure fit and proper people were employed. There was a system for checking nurses were validated with the Nursing and Midwifery Council (NMC).

Using medicines safely
● People were not always supported to take their medicines in a timely way. Some families raised concerns about delays in people receiving their medicines and we observed that people were still being supported to taking their morning medication until lunch time on one unit.
● People's prescribed creams were not always securely stored in people's bedrooms. We found examples where the storage of creams was not in line with good practice guidance and where a person had obtained a medicine that should not have been accessible to them.

We found no evidence that people had been significantly harmed. However, the systems in place were not robust enough to demonstrate safety of medicines was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were designated medicines rooms where medicines were being stored. Temperature checks were in place. An electronic medicine administration records (eMARs) was being used which included information about people's allergies and guidance on how to support people who required medicines 'as and when' needed, such as medicines for pain.

Assessing risk, safety monitoring and management
● People's individual risk assessment did not always clearly evidence that risk had been accurately assessed and how staff should act to reduce risk as much as possible. For example, where people required safety checks, support with pressure relief or additional support to maintain a healthy diet, information was often limited or inconsistently documented within the records. At out last inspection we found similar concerns around the accuracy of people's health and safety risk documentation.
● Staff told us they often did not have time to read people's care plans and would rely on information from more experience staff members when establishing what support a person needed.
● The service had systems for ensuring utilities such as electrical and gas equipment was maintained appropriately. Maintenance checks were completed, and remedial action taken when needed. Environmental risk assessments had been completed but were not readily accessible to staff. This is discussed further in the well led section of this report.

The provide had failed to ensure that systems were in place and robust enough to effectively manage and mitigate risk and ensure people received the safe care they needed. We found no evidence that people had been significantly harmed, however, this placed people at risk of harm. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Cleaners were on site throughout the day and worked hard to maintain a clean environment. We noted some damaged or unsuitable furnishings in people's bedrooms which made good infection control practice difficult. The provider advised that remedial action had been completed following the inspection.
● PPE was readily available to visitors and staff at the entrance of units and, on the day, we observed all staff were wearing this correctly in line with the current guidance. Some relatives told us that when they had visited the service they had noted that staff were not always wearing PPE correctly. All staff had completed relevant training in the use of PPE and their competency in this area had been assessed.
● The service was fully engaged in the Covid-19 testing regime for staff and people living at Mersey Parks Care Home and supported people who needed to shield. People were supported to access the Covid-19 vaccination programme.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training in safeguarding people from abuse although a number of staff needed refresher training in this area at the time of inspection. The manager advised this was an area of ongoing work and provided evidence of improved levels of training following inspection.
● People and relatives generally told us they felt people were safe and well cared for at Mersey Parks Care Home. One person said, "I am very happy here. I love it here the staff are so good to me," and a relative said "[Family member] is comfortable with staff and looks well cared for. I have no concerns at all."

Learning lessons when things go wrong

● Records were kept of accidents and incidents that occurred to people who used the service and to staff. However, these were not always analysed to identify action, patterns or themes that could prevent future risk. It was not always clear how this learning had been implemented across the units at Mersey Parks Care Home. We have addressed this in the well-led section of this report.

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's care needs had been assessed and risk assessments and care plans were in place. However, the quality of these varied. We noted that care plans were not always person-centred and lacked the detail need to support people effectively.
- Care plans were not always updated to reflect a person's current needs. We found examples where people had specific needs, but the relevant care plans had not been put in place. Care plans were not always amended to show how people's needs had changed meaning that staff could not be clear on how to support people appropriately.
- We received mixed feedback from people about their experience of how care was delivered. Some people were very happy with the care they received whilst others raised concerns that their preferences were not always met in a timely way, for example in relation to personal care.
- We observed people received limited social interaction and stimulation. Staff were very busy and unable to spend time chatting with people or reminiscing although people's care plans referred to these preferences.

The provider had failed to ensure staff provided people with individualised care which met their needs. This placed people at risk of harm. This demonstrates a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The service had completed a refurbishment of communal areas on all units and these areas were clean and tidy. However, we found that bedrooms needed attention and some furniture was in need of repair. It was not clear that these had been identified during checks of the environment. At our last inspection we found similar issues that outstanding repairs were not always completed in a timely way.
- The home was not always adapted to meet the needs of the people living in the unit. We visited one residential dementia unit and found this had not been adapted to meet the needs of people living with dementia, in line with good practice, to help people remain independent. This had been identified as area within the action plan. However, limited progress had been made at the time of this inspection.

The provider had failed to identify and address shortfalls within the environment and ensure the premises were suitable for the purpose they were being used. The issues described above demonstrates a breach of Regulation 15 (Premise and Equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff completed an induction and a range of training the provider considered mandatory. However, records showed that staff had not completed all the required training. This shortfall had been identified by the new manager and steps were being taken to ensure staff were up to date with all training.

● We saw that staff had supervisions, however records showed that the identified supervision due date for the majority of staff had passed. The manager told us this was an area they had identified and were addressing. Following the inspection, the new manager provided evidence that staff had all had a recent supervision. However, our previous inspection identified a similar shortfall and the manager at that time assured us that this would be addressed in line with provider policy.

● Staff gave mixed feedback about how they had been supported within their roles. Some staff talked positively about the encouragement and support they had received, whilst other staff felt unsupported and told us that management were dismissive of concerns they raised.

We found no evidence that people had been harmed, but the provider had failed to ensure staff received appropriate training and support to carry out their roles. This placed people at risk of harm. This was a further breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● People told us the food was good. One person said, "I do eat very well and I get plenty of drinks." The food smelt good and people who could eat unaided appeared to be enjoying their meal. Staff were not always able to give people the encouragement they required to eat a balance diet, and we saw examples where people who required additional support had eaten very little of their meal.

● Staff would identify when people required modified diets and would make appropriate referrals to the speech and language team for assessment. The chef knew who required modified diets, however it was not always clear how people who had specific needs, such as a vegetarian diet, were provided with choice.

● People had care plans in place in relation to eating and drinking. However, when a person's needs changed, for example where guidance had been provided by a dietician because of weight loss, care plans were not always rewritten to reflect this and review records did not always include a full and clear overview of changes.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was a system for monitoring falls. Appropriate action was taken in response to individual's accidents and medical attention was sought.

● Staff identified when people's needs changed and would make referrals for assessment and equipment to meet an individual's needs, although documentation in care records was not always clear.

● Relatives gave us mixed feedback about their experiences in this area. Some had very positive experiences and told us the service was proactive and communicated well when people's needs changes. One relative said, "They call out health care professionals as necessary and keep me informed." However, other relatives had less positive experiences and gave examples of delays in people's needs being met in relation to medicines and referrals to external services. One relative told us, "They can be reluctant to share information. I had to push for them to make a referral, they did not suggest it."

● Health care professionals were supported to assess people living at Mersey Parks Care Home. On the day of inspection, a podiatrist was visiting people on one unit and the new manager told us they staff would support assessments via video calls as needed.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The service identified and submitted applications when people were subject to restrictions through the DoLS process. We noted that many people were still awaiting assessment and care records did not clearly document what steps were in place to ensure any restrictions were lawful or how applications were being followed up.
● Capacity assessments and best interest decision records were in place. Records did not always demonstrate that relevant people were involved in the decision-making process or that this process had been completed for all relevant specific decisions where people lacked capacity. Staff lacked a good understanding in this area. At our last inspection we found similar issues in relation to staff's understanding of MCA and DoLS.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in July 2019 we identified two breaches relating to staffing and good governance and rated the service as Requires Improvement. At this inspection we found that improvements had not been made and identified five breaches of the regulations. This meant that compliance with the regulations was not sustained and consistency of good practice was not demonstrated.

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

At our last inspection the provider had not always ensured governance and monitoring systems had been effectively operated to maintain people's safety and drive improvement and had not ensured that information about people's needs was consistent, accurate and up to date. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● The service had a detailed action plan in place. We found that limited progress had been made on this since our last inspection and assurance given at our last inspection had not been effectively implemented. This included concerns regarding premises, staff training and supervision, in addition to the breaches of regulation identified regarding good governance and staffing.
● Systems in place for the oversight and monitoring of the service were not sufficiently robust. The service undertook some daily, weekly and monthly quality assurance checks and audits but we found analysis of information did not identify action, patterns or themes that could prevent future risk. The concerns found during this inspection in relation to record keeping and premises demonstrated these systems were not always sufficiently comprehensive to identify or address shortfalls in a timely manner.

The provider had failed to ensure systems for governance and oversight were robust and effective to address concerns and identify shortfalls to keep people safe and drive improvement across the service This placed people at risk of harm. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had a range of policies and procedures to guide staff on what was expected of them in their roles.

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

outcomes for people
● Due to the Covid-19 pandemic staff and relatives' meetings had not be held. The provider produced a regular newsletter to inform people of national events and information. However, families had received limited communication specific to Mersey Parks Care Home. The majority of relatives we spoke with told us they had not been aware of what arrangements had been in place for the management of the service prior to the new manager entering post.
● There were daily meetings for managers and staff to discuss important issues, and the care of people who used the service.

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
● People and relatives generally spoke highly of the staff and unit managers. One relative told us, "The unit manager is very good. They are straight talking and will sort things out. They are very approachable." However, other relatives had less positive experiences and told us, "The quality of communication depends on the staff, some are great but others you have to keep asking."
● The provider had submitted some statutory notifications to the CQC. Statutory notifications are certain changes, events and incidents that the Registered providers must notify us about that affect their service or the people who use it. Since we visited the service, we found the provider had not sent some required notifications to the CQC in a timely way. This is a potential breach of Regulation 18: Notification of other incidents of Care Quality Commission (Registration) Regulations 2009. We will follow our processes to consider an appropriate response to this outside inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People who lived at Mersey Parks Care Home and their relatives had opportunities to comment on the way the service was run and the support they received. Satisfaction surveys had been completed with people who used the service, relatives and staff.
● People and relatives generally told us they felt able to raise concerns and make complaints. We received feedback on various experiences of how these had been addressed. Some people told us they were satisfied with responses and others felt that not enough action had been taken in response to their concerns.
●There was a statement of purpose and a service user guide. These gave people details of the facilities provided at this care home. These explained the service's aims, values, objectives and services provided.
● The service worked with other local services to meet people's needs. Prior to the pandemic the local authority had supported the service with input from social workers.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's individual care needs were not always being met in line with their current support needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's prescribed creams were not always being stored in line with service policies and good practice guidance. People were not always having support needs met in a timely way based on their current care needs; individual risk assessments did not always provide sufficient guidance on how risk could be mitigated and environmental risk assessments were not readily available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Not all units within the home had been adapted to meet the needs of the people living there; systems for environmental checks were not robust to ensure that damaged furniture and equipment was identified and actioned in a timely manner.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

There were not always enough staff to meet the needs of people living at Mersey Parks Care Home in a timely way.

Staff had not always had the training and supervision they needed to undertake their roles.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems for governance and improving the quality of service were not robustly and effectively implemented across the service. Issues found at previous inspections had not been resolved at this inspection and action taken had either not been implemented appropriately and consistently or effectively reviewed to ensure concerns had been resolved.

The enforcement action we took:

Warning notice issued