Tudor Bank Limited

Alt Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Alt Park Nursing Home is a residential care home providing personal and nursing care for up to 35 people aged 65 and over. At the time of the inspection there were 33 people who used the service.

People's experience of using the service and what we found
The service was not well-led. The manager and provider failed to carry out their regulatory responsibilities. Quality assurance processes were ineffective. During the inspection the senior management team and nominated individual ensured immediate actions were taken to mitigate the failures highlighted in this report. However, we are not yet assured these actions were effective or embedded to ensure the quality and safety of the service was consistently monitored and improved to keep people safe.

People were at risk of avoidable harm because accidents and incidents were not always assessed, recorded, or manged effectively to prevent further incidents. Staff were not subject to safe or robust recruitment checks. Staff were not provided with effective guidance to know how to keep people safe from harm. Medicines were not managed safely and placed people at avoidable harm. Covert medications were not administered in line with policies and procedures and as and when required medication protocols were insufficient.

People were at risk of harm because health and safety checks within the building were not effective and did not always evidence hazards were actioned within a timely manner. Trip hazards in communal areas had not been addressed to prevent falls. Appropriate measures had not been taken to ensure the safety of people in the event of an emergency. Good infection prevention and control measures were not always followed by staff. This put people at risk of infection and harm.

People were at risk of receiving care that did not meet their needs records were either incomplete, inaccurate, or lacked detail to provide staff with guidance on how to support people appropriately. People were not always supported to make informed decisions about their care in a person-centred or timely way.

People's privacy and dignity was not always maintained. Communal bathrooms did not have handles to close the door, and several doors had no lock. Many areas were in need of decoration including people's bedrooms and communal areas.

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.

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

Rating at last inspection
The last rating for this service was good (published 21 September 2021).

Why we inspected
The inspection was prompted due to CQC receiving multiple concerns regarding the management of the home, people not being sufficiently hydrated and concerns relating to a poor culture within the service.

A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. However, during the inspection further risks were identified which resulted in all key questions being reviewed to include, effective, caring, and responsive.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified multiple breaches in relation to protecting people from the risk of abuse, the delivery of safe care and treatment, and good governance. We also identified breaches in ensuring people received care in a way which promoted dignity and respect and person-centred care. Staff were not safely recruited and there was a failure to ensure people's rights were upheld in line with the Mental Capacity Act 2005.

Please see the action we have told the provider to take, and what action CQC has taken at the end of this report.

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Alt Park Nursing Home

Detailed findings

Background to this inspection

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

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
This inspection was carried out by two inspectors.

Service and service type
Alt Park Nursing Home is a 'care home'. People in care services receive accommodation and nursing or personal care as single package under one contractual agreement dependent on their registration with us. Alt Park is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, there was a home manager who was in the process of registering with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We looked around the premises, observed the interactions between people living at the home, care delivery and activities provided for people.

We spoke with 5 people who used the service and 5 relatives about their experience of the care provided. We spoke with 10 members of staff including the home manager, deputy manager, regional manager, clinical support nurse, interim manager, nurses, senior care workers and care workers.

We looked at a range of documentation during the inspection. This included care records for 5 people and their medication records. Safer recruitment checks were completed for 3 staff members. Health and safety records including accident and incidents, safeguarding records were also reviewed. Along with audits relating to quality checks undertaken by staff and managers.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- People's risks had not been adequately assessed and mitigated.
- Risk assessments were either not completed, not accurate or reflective of people's current needs, or detailed enough to guide staff on safely supporting people. For example, 1 person was assessed as requiring bed rails. However, a bed rails risk assessment had not been completed to ensure this was safe.
- Some people were at risk from weight loss and required weekly weight monitoring. Records demonstrated people were only being weighed monthly. This placed people at further risk of harm.
- Systems for recording incidents and lessons learnt were not in place to reduce the risk of further occurrence. Accident and incident analysis was not being completed.
- Information required in the event of a fire was not easily accessible. Personal emergency evacuation plans (PEEPs) were not in place for all people, and some remained in place for people who were no longer at the home.

Risks to people's health, safety and welfare had not been suitably assessed. There was also a lack of detail in care plans to demonstrate how risk was to be mitigated. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Systems were not in place to manage medicines safely.
- Unsafe medication practices were observed for people who required covert medicines (hidden in food or drink). People were not observed when taking medications covertly, resulting in medications not being administered safely or on time.
- Medication competency assessments had not been completed prior to staff administering medicines.
- Protocols were in place for people who took medicines on an 'as required' basis, however, these were not detailed.
- Some people were prescribed transdermal patches for support with pain management. Records failed to evidence rotation of the patch as per recommended guidelines.
- Medicines audits were completed but were ineffective. When concerns had been identified there was not always timely action to address the concern.

Medicines were not managed safely. This placed people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● People were not protected from the risks of infection.
● The provider was not promoting safety through appropriate hygiene practices. Many areas of the home were in need of decoration, with damaged bathrooms and chipped paintwork. This meant it was not always possible to clean these areas effectively.
Staff were observed not using and disposing of PPE safely.
● Cleaning schedules were not appropriate to prevent the spread of infection.

Systems were not in place or were ineffective in protecting people from the risk of infection through an unclean environment and unsafe staff practices. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse because processes were not always followed.
● Safeguarding incidents which were recorded had not always been investigated appropriately by the home manager or provider and action had not always been taken to reduce the risk of abuse. There were some repeated incidents of people entering other people's bedrooms and hitting out at them. These incidents had not been appropriately reviewed and no actions had been taken to review plans or people's needs to ensure the risk to others was reduced.
● Not all staff were aware of their responsibilities regarding safeguarding. Staff were not aware of how to raise concerns outside of the home manager if they felt appropriate action had not been taken.

People were not adequately protected from the risk of abuse and the provider failed to ensure appropriate systems were followed. This placed people at risk of harm. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not always recruited safely.
● Staff recruitment files were missing information, which included gaps in employment history.
● For 2 staff members references had not been obtained from their previous employer.
● Whilst there were enough staff to support people, the deployment and lack of leadership of staff resulted in staff members congregating in certain areas throughout the home which resulted in people on the first floor waiting longer for call bells to be answered. On the day of the inspection there was one nurse on duty who was responsible for medicines and clinical oversight of 32 people.
The management and deployment of staff resulted in peoples care needs not being met within a timely manner. This placed people at risk of harm. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
After the inspection the provider took action to address the concerns relating to recruitment processes.

Inadequate

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People's needs were not fully assessed, reviewed, or documented to inform staff of what care and support they required.
- Advice and guidance provided by health care professionals was not always incorporated or available in people's plans of care.
- Care records failed to take account of people's needs including health, emotional, spiritual and cultural needs.

Staff did not have access to robust care plans which were needed to support people effectively. This placed people at risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- Some people had bed rails in place. There was no evidence that people's consent to bed rails had been sought.
- Care plans did not reflect consent for the use of CCTV within the building and did not evidence consent for 1:1 support.
- Where a person was unable to consent, there was no evidence their ability to consent had been assessed, or that decisions had been made in the person's best interest.

● DoLS which had been applied for did not make reference to 1:1 support in place.
● Best interest decisions which were in place were not completed adequately and did not include other people in decision making.

Effective systems were not in place to ensure people's rights were maintained under the Mental Capacity Act. This placed people at risk of harm. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● Some dementia friendly signage was displayed on the walls within communal areas; however, the lounge and dining room sign was pointing to the incorrect room. This would not support people to identify rooms easily.
● Most people's bedrooms contained damaged furniture and damaged walls and flooring that had not been repaired or adequately cleaned. People had an unsafe living environment.
● It was difficult to identify people's bedrooms due to a lack of photograph and names outside the door.
● It had been recognised by the provider that parts of the building needed significant repair and some refurbishment. They had a plan to improve areas but there was no urgency in the timescales identified for completion. There were health and safety hazards throughout the service that had not been identified or actioned by the provider in a timely manner.

Systems to ensure the environment was safe were inadequate. This placed people at risk of harm and a breach of regulation 15 premises and equipment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not always have their nutritional needs and wishes met.
● Staff were not aware of all people's dietary needs or preferences.
● For example, people's records regarding fluid intake and personal care were incomplete, staff told us they did not always have the time to complete records. Fluid records indicated people were not sufficiently hydrated.

Staff support: induction, training, skills and experience
● Staff had received training, however the training matrix provided evidenced some staff training was out of date and future training had not been planned.
● Staff had received formal supervisions. However, we received mixed feedback from staff supervision was not offered to everyone equally on a regular basis. Some staff reported they did not have enough supervision which resulted in a lack of support and leadership.
● The provider had put additional supervision in place to support staff following the inspection.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
● Systems were in place for people to have access to the healthcare support they required. GP services and associated health care professionals visited the service on a regular basis to monitor people's health. We asked to see evidence of referrals to other services and records could not always be located due to a recent change in the providers care plan system. Assurances were provide following the inspection that all referrals to have professionals were completed.

Inadequate

Is the service caring?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Respecting and promoting people's privacy, dignity and independence
- People's privacy, dignity and independence was not always maintained.
- Communal bathrooms did not always have handles to close the door, and most had no lock. One person said, "How am I supposed to go to the toilet."
- People did not always have privacy in their own bedroom. Some people were known to enter other people's bedrooms uninvited and care records stated staff could not stop this.
- People had to wait for their needs to be met. We observed 1 person shout for help who did not have access to a call bell as it was out of reach. They waited 4 minutes for a staff member attend; however, they were unable to provide support as additional staff were required. This resulted in further delays of 4 minutes until two carers attended to provide support.

Effective systems were not in place to ensure people's privacy, dignity and independence were maintained. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring people are well treated and supported; respecting equality and diversity
- People were being supported by agency staff on 1:1 who did not know them well and there were barriers with language and communication. We observed staff using their hands to communicate with people who did not understand. Staff did not always speak to people using clear short understandable sentences.
- Staff spoken to were able to explain the needs of people, however records of care delivered were inconsistently completed and did not show people had been supported with their needs or preferences.

Supporting people to express their views and be involved in making decisions about their care
- People's wishes had not always been documented appropriately. Conversations with relatives indicated there were mixed opinions about the care their family member received.
- Relatives with the appropriate legal authority were not always included in discussions about people's care. Relatives told us they had not seen their family members care plan or been consulted about their care needs (when appropriate). One relative said, "I've never seen notes or a care plan. I've never been involved in those discussions."

Inadequate

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

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

- Care plans were not person-centred and did not contain information relating to the individual needs or preferences of people.
- A relative said they had never been asked about preference for gender of staff (where appropriate)and told us their loved one would prefer a female staff member.
- Specific care plans for medical conditions or risks were not in place.
- Care records failed to take account of people's needs including health, emotional, spiritual, and cultural needs.

Systems to ensure appropriate care records were in place were inadequate . This evidenced a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

- Some care plans contained information regarding people's communication needs, however. some did not. This meant staff did not always have the appropriate information to be able communicate effectively.

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

- There was no activity coordinator employed by the provider and staff spoken with stated it was difficult to find the time to provide activities for people alongside their current role. Activities were not planned for people and there was lack of stimulation in the communal areas. The provider informed us an activity co-ordinator had been recruited and was waiting to start.

Improving care quality in response to complaints or concerns

- There was a complaints procedure available to people and visitors.
- Some relatives and staff told us they didn't feel comfortable raising concerns. When issues had been raised, they had not always been actioned or used to improve quality and safety of the service. For example, a relative had raised concerns about unexplained bruising and concerns regarding the use of restraint and advised inspectors there had been no investigation into this to explore these concerns.

End of life care and support

● Care plans did not contain information regarding peoples advanced care planning or end of life needs and wishes. This meant staff did not have the appropriate information to be able to effectively support people according to their wishes.

Systems were not in place to plan for end-of-life care and support resulting in staff not knowing peoples wishes or preferences, This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- The governance and leadership within the service was ineffective. Nursing staff were tasked with the management, oversight, directing and monitoring of staff teams in addition to all clinical duties. This meant they were unable to adequately prioritise review of people's health conditions and administering medicines that were time bound.
- Governance systems failed to drive necessary improvements to the safety and quality of the service. Audits were ineffective and when checks were completed there was no oversight when issues were identified, and no action was taken to address issues.
- The provider failed to maintain accurate, complete, and contemporaneous records to demonstrate complaints were managed effectively, the safe care and treatment of people and safe recruitment of staff.
- There had been a significant lack of management. Notifiable incidents had not always been reported to CQC as required.
- Systems to record and investigate accidents and incidents were not always followed. Analysis was not robust enough to prevent further incidents.

The provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff and ensure appropriate training was available to mitigate risks to people. This is a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider responded and gathered information for CQC to provide assurances for the immediate risks to people's health and well-being. An interim manager was appointed to work at the service to support improvement at the end of the inspection.

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

- The management team had not developed a proactive culture that was effectively monitoring people's safety and wellbeing. There was a culture of blaming others and blaming systems when something was missed.
- Staff advised there was poor morale within the service and a lack of understanding of expectations. Staff described working at Alt Park Nursing Home as 'chaos' and 'confusing at times'.
- Staff were not clear about their roles, and this put people at risk of not receiving the care and support they

needed.

Systems were not in place to proactively monitor people's safety and wellbeing. This is a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We could not always be certain that all referrals to health and social care professionals had been completed in a timely manner. The management team was unable to evidence referrals were made to other agencies when needed. Care plans and risk assessments did not evidence the outcome of referrals and advice to be followed.

● Relatives told us they had not been involved in care planning or reviews of care plan information (where appropriate).

● Staff told us they felt the management team did not always listen when they raised concerns about the service.

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 11 HSCA RA Regulations 2014 Need for consent Effective systems were not in place to ensure people's rights were maintained under the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not adequately protected from the risk of abuse and the provider failed to ensure appropriate systems were followed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Effective systems were not in place to ensure the environment was safe for people

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people's health, safety and welfare had not been suitably assessed. There was also a lack of detail in care plans to demonstrate how risk was to be mitigated. Medicines were not managed safely. Systems were not in place or ineffective in protecting people from the risk of infection through an unclean environment and unsafe staff practices.

The enforcement action we took:

Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Staff did not have access to robust care plans which were needed to support people effectively. The provider had failed to assess and monitor the service for quality and safety; deploy and manage staff delivering care and support; maintain accurate records for people and staff and ensure appropriate training was available to mitigate risks to people.

The enforcement action we took:

Warning Notice.