Canaryford Limited

Parklands Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: Parklands is a purpose-built nursing home for up to 54 older people who may also have care needs associated with living with dementia. At the time of inspection 47 people were receiving a service, some on the end of life pathway.

People's experience of using this service:
People and relatives on the day of inspection spoke positivity about the service, particularly about the caring and compassionate nature of care staff and nurses, and we observed this in care observations.

However, we found that the service was not safe or well led.
Care plans for people with complex needs were not person centred and did not adequately address how staff should manage individual identified risks. This included people at risk of developing pressure ulcers, and those who remained cared for in bed with use of bedrails.

People and staff told us, whilst there were sufficient care staff to meet people's basic needs, there were not enough nurses. Nursing staff had multiple responsibilities and struggled to complete the required audits and paperwork to ensure that the service provided was safe.

Medicines were not robustly audited to ensure safe practice. People told us that medication administration was not person centred.

Care staff told us they didn't have time to sit and chat with people in their bedrooms, and some people told us they were lonely and felt isolated and depressed.

The provider did not have a dependency tool, used to calculate the numbers of staff needed to care for people with highly complex needs, the frequent admissions, reviews and various nursing tasks.

The registered manager had not ensured that registered staff and care staff had received appropriate supervision and appraisal to check competency or any concerns staff might have about the service.

The registered manager had poor oversight of the service and did not have robust governance systems in place to ensure the quality of the service. They had not been notifying the appropriate agencies when people were identified at risk or had experienced poor health following incidents and accidents. Information relating to incident and accidents was not used to identify or mitigate future risks.

Rating at last inspection: This service was rated good, with the previous report being published on the 27 June 2017.

Why we inspected: This inspection was brought forward due to information of risk to people following high number of safeguarding alerts.

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

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

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures.

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

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 well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Parklands Nursing Home

Detailed findings

Background to this inspection

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
Include as appropriate This was an focused inspection looking at whether the service was safe and well led, and was prompted in part by concerns raised from the Local Safeguarding Authority.

Inspection team:
The inspection team consisted of one inspector and one assistant inspector.

Service and service type:
Parklands nursing home is registered to accommodate up to 54 people who have nursing needs and may or may not be living with dementia. This service also provides fast track from hospital for people requiring end of life care and treatment, and for people who are being discharged from hospital to be assessed for permanent residential or nursing placement. At the time of inspection 47 people were living at the service. The service had a manager registered with the Care Quality Commission. This means that they 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 was an unannounced inspection.

What we did:
Before the inspection we looked at all the information we held about the service. Including notifications made to us from the service and concerns raised from external agencies. We wrote to the provider and requested some information relating to these concerns. The response prompted this inspection to take place.
During the inspection we spoke to a variety of staff working at the service. This included the registered

manager, the provider, two registered nurses, five care staff, and a domestic assistant.

We also spoke with ten people living at the service and four relatives.
We reviewed a number of the services policies and procedures, incident and accident folders, eight care records for people living at the service with complex needs, and any observations that staff carried out on people living at the service where this was an identified need.
We reviewed three staff recruitment files, environmental safety checks carried out at service and any documentation held to monitor the quality of the service provided.
Following the inspection, we wrote to the provider and they sent us an action plan about how they would address the shortfalls identified during the inspection.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Systems and processes to safeguard people from the risk of abuse

- The registered manager had not reported to the commission 14 separate incidents that are reportable under the Health and Social Care Act, 2014. These incidents included potential abuse and serious injuries, for example fractures following a fall.
- The provider had a safeguarding policy in place that had been reviewed by the registered manager yearly. This policy identified the action that the investigating officer should take to raise concerns. This included the responsibility to notify the local safeguarding adults board and the Care Quality Commission.
- The registered manager had not submitted death notifications to the commission for a number of months. This is a legal requirement.

This is a breach of Regulation 18 of the Registrations Regulations, 2009; Notifications.

- The registered manager confirmed that staff should receive annual safeguarding training updates. However, of 56 staff, eight members of staff were out of date by eight to eleven months, and 11 staff who had most recently commenced employment had not received safeguarding vulnerable adults training.

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

- The registered manager had adapted a bedrail risk assessment form provided by the local authority quality improvement team. This was following very poor risk assessments in this area. However, of the three people that had a new risk assessment, forms had not been completed in full. This included not evidencing that gaps between mattresses and rails had been identified. One person was highlighted as at risk of climbing over rails, but bedrails were still put in place.
- We observed high numbers of people cared for in bed, with use of bedrails who did not have bumpers in place. Bedrail bumpers are a preventative measure to mitigate the risk of people getting limbs caught and sustaining an injury. Where bumpers were in place, sometimes only one rail would be covered. Some bumpers were in very poor condition. The registered manager told us, "We have just purchased 25 sets. I can't believe they have not been used." They had not completed checks to ensure that this been actioned.
- The registered manager and nursing staff had not carried out capacity assessments for people who had bedrails in place. Bedrails are a restrictive practice and if people lack capacity to consent then a service must be able to demonstrate that they are in the persons best interest. The registered manager was not aware that they should apply for deprivation of liberty safeguards to demonstrate bed rails were the least restrictive option to keep people safe.
- Staff recorded incidents such as falls and pressure ulcers, however these incidents were not used to find common cause or mitigate future risk. Many of the falls had happened in the evening or early hours of the morning. This information had not been used to review staffing levels and any other potential cause.
- People at high risk of developing pressure ulcers were not repositioned regularly in line with their care plan interventions to manage this risk. A number of staff we spoke to told us people did not need

repositioning as they were cared for on an airflow mattress. The registered manager told us, "I have told staff before that repositioning is important for blood flow, to provide air to skin and for general good health."
● People cared for in bed had positioning charts in place, but they did not have how often the person should be repositioned. Turn charts were completed hourly and we found that people were cared for on their backs throughout the day and this was documented in repositioning charts. Staff told us, "There are only a couple of high risk people needing turning, including [person name]." However, we checked this person's chart and found they had remained on their back throughout the day despite existing pressure ulcers.
● The registered manager did not take immediate actions when failings were identified by external professionals. They did not analysis accident and incident forms. Consequently, they were not learning lessons when things went wrong at the service.

This was a breach of Regulation 12 of the Health and Social Care Act, 2014; Safe care and Treatment

Staffing and recruitment
● Staff told us that staffing had not increased following the start of the service providing assessment for discharge from hospitals, a fast turnaround service despite the increase in nursing duties. Whilst the provider had increased staff in recent weeks, staff told us, "We need someone extra to manage the various reviews, admissions and flow of visitors and health professionals."
● Relatives, people living at the service and care staff told us that whilst there were sufficient care staff there was a lack of registered nurses to manage all the various tasks assigned. This included daily paperwork, oversight of junior staff, nursing care tasks, admissions, managing deaths of people at the end of life and lengthy reviews with external stakeholders.
● The provider did not have a dependency tool to identify how many staff would be needed in relation to the dependency needs of people and the additional care activities for a high turn around service.
● The commission had received complaints from a relative that their loved ones had been neglected due to lack of staffing. This included being left in urine for prolong periods at night, and staff not answering buzzers quickly. Following inspection, we received complaints of a similar concern which were raised as a safeguarding by external health and social care professionals.
● Care staff told us that they had limited time to sit and chat to people, many of whom were cared for in their bedrooms. People cared for in bed, and who could talk to us, told us that they sometimes felt lonely and isolated and this had affected their mental health. One person said, "I feel so lonely sometimes. They are all busy and lovely girls, but I hate to ask them if they will take me to the lounge because they are rushed off their feet in the morning." Another person receiving end of life care told us in tears, "I am lonely in here but I can't leave my bed. The Carers are lovely and say they will come back and talk to me, but they never come back because they are too busy and forget. It's been so nice to talk to you."

This was a breach of Regulation 18 of the Health and Social Care Act 2014; Staffing.

Using medicines safely
● Nursing staff had the responsibility for carrying out weekly medication audits. However, the registered manager could only produce one for the month of May and no audits prior to this. This audit identified missed signatures and that staff were not always recording how much as required medicines, such as paracetamol were given. The audits were given to the manager to action, but they were not using the audit to take appropriate actions to ensure that medicines management improved.
● Qualified nursing staff administrated medicines to people who needed it. The provider had recently booked updated medication training for nurses.
● Medicines were stored safely. There was safe storage for controlled drugs and we observed that two staff always signed control drugs out of the secure cupboard.

● Clinical room temperatures were being recorded.
● However, we observed that some people were given their medication at meal times. One person who received injections told us, "Who wants an injection in your stomach while you try and eat?" We discussed this with the provider and nurse in charge to review this process.
● Several people told us that staff gave medicines to them on a spoon or in a syringe without explaining what they were for. One person said, "I tell them no, I want to know what I am taking, not just take everything at once off a spoon."
● The provider told us they had booked a medication refresher course for registered nurses and this had been booked and paid for in advance of the inspection.

Preventing and controlling infection
● Staff adhered to good infection control procedures and had access to protective wear such as aprons and gloves.
● The service was kept clean and tidy. A support manager carried out regular spot checks on staff to ensure the environment was clean and free from infection risk.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

- The registered manager had poor oversight of the care provided to people. They did not complete any quality audits at the service. They told us that some audits were completed by registered nurses, but they did not review this information.
- The registered manger told us they had not completed supervisions for registered nurses for some time. They confirmed this was their responsibility and said, "I do talk to staff informally as things occur. I do not write it down." Most staff we spoke to could not remember when they had last received supervision.
- External health and social care professionals had highlighted several safeguarding concerns and quality monitoring at the service over recent weeks. However, the registered manager had not increased their oversight of the service to check that actions had been taken by staff. The registered manager told us, "I don't do a walk round as such, if staff need me they come to the office and I see them throughout the day."
- Providers registered with the commission are required to submit a PIR. This is a provider information return, a report detailing how the service operated. However, the provider had not submitted the return as required.
- The provider had not recruited into the deputy manager role, following the deputy manager leaving several months prior to inspection. The registered manager told us that this had meant they felt overwhelmed at times due to volume of work. However, on the day of inspection, the provider had recruited an interim deputy manager.
- The registered manager did not carry out random spot checks of peoples care plans and risk assessments to ensure the quality of these. Registered nursing staff completed care plans and risk assessments. However, of the six reviewed, these contained little information about people's preferences, wishes, and equality characteristics. Where a care need was identified, instructions of how staff should manage these needs was vague.
- The provider had not assured themselves that the quality of the service provided was good. They did not carry out their own quality checks. They told us they regularly met with the manager to discuss issues at the home but had not recorded these to demonstrate what had been discussed and agreed regarding the service.

This is a breach of Regulation 17, of the Health and Social Care Act, 2014; Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The registered manager was unable to tell us how people were engaged and involved in the running of the service. They told us, "When I previously managed homes I would carry out resident and relative satisfaction surveys, but I haven't done that here."
● People living at the service were not involved in planning the decorations. The registered manager told us, "I picked the colour of the carpets when we needed to replace them with the director. At previous homes we let people choose the colour of the carpets but they made a bad choice and the carpets got stained quickly."
● People living with disability and illness where not always involved in planning their care. Some people we spoke with didn't know what their care plan was. Others expressed that they wanted to do somethings for themselves, such as administer their own medications, but staff did not ask these questions.
● The registered manger told us that the activity person carried out resident meetings. They told us, "I don't attend the meetings but I did ask the activity person to tell me when they were on but they always tell me afterwards." They had not followed this up with the member of staff or made additional enquires about any positive suggestions about the service from people.
● Visiting health and social care professionals observed that on visiting a person cared for in a shared room, care staff entered and began to provide personal care to the second person, without screening the person from site. Staff did not understand the need to protect both persons dignity, demonstrating a lack of understanding of ensuring privacy and dignity to people.

This is a Breach of Regulation 9 of the Health and Social Care Act, 2014; Person centred care.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility
● The registered manager told us they did not inform the provider that they were behind in their responsibilities and they "Liked to put on a brave face." However, this resulted in the quality of care at the service deteriorating.
● The registered manager had failed in their responsibilities to complete safeguarding notifications to the relevant agencies. They had not undertaken appropriate investigations following incidents and accidents. These failing resulted in lack of duty of candour and learning to mitigate future risks.
● The registered manager did not audit care plans, care records or carry out daily walk rounds of the service to check that people received person centred care.
● People told us that if they had raised concerns or a complaint they did not hear from the registered manager the outcome of these complaints. One person told us, "a member of staff was very rude to my relative. I made a complaint to the [registered manager], but I didn't hear the outcome."
● The registered manager had not proactively acted on the shortfalls identified by external health and social care professionals. The lack of oversight meant that poor care was not always identified. Where it had been identified inaction resulted in people remaining at risk of harm.

This was a breach of Regulation 7 of the Health and Social Care Act, registered managers.

Working in partnership with others
● Staff told us they had a good relationship with external palliative nurse team who supported people fast tracked to the service for end of life care.
● People had access to dentist appointments and hospital appointments and staff supported these visits.
● People who required additional assessments to manage deteriorating needs, such as difficulty swallowing, were referred for speech and language assessments.
● Nursing staff carried out regular reviews with local commission teams for people that had been admitted to the service for assessment for discharge.

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 registered persons had not submitted required notifications relating to deaths, safeguarding concerns and incidents and accidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not always involved in the planning of their care and development of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers The registered manager had not followed the providers systems and processes, nor the regulatory requirements under the fundamental standards. This had contributed to the failings at the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems and processes in place to monitor peoples safety were insufficient and people were at risk of receiving unsafe care and treatment.

The enforcement action we took:

The service was placed in special measures and the provider was required to demonstrate how they would appropriately identify peoples individual needs and how these would be managed to ensure safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Poor governance and quality assurance across all levels contributed to failings found at the service.

The enforcement action we took:

The service was placed in special measures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service had not used peoples identified dependency needs and additional service needs, to identify the numbers of qualified and unqualified staff required to provide safe care and treatment.

The enforcement action we took:

The service was placed in special measures and the provider was required to produce an action plan that demonstrated how staffing numbers would be assessed to ensure peoples safe care and treatment.