Mrs Kim Crosskey

Pearson Park Care 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?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Pearson Park Care Home is a residential care home providing personal care to 19 people, some of whom may be living with dementia and mental health needs. The service can support up to 24 people. It accommodates people in one adapted building and bedrooms are both single and double occupancy.

People's experience of using this service and what we found
The provider had failed to implement systems and processes to assess the risks to people's safety which put people at risk of harm. Care and support was task-based and people were subjected to degrading care as a result. There were not enough staff to keep people safe and standards of hygiene had not been maintained. Safety-related incidents had not been investigated to prevent reoccurrence.

Not all staff had kept up to date with their mandatory training and not all staff had not received training in key areas such as dementia and mental health. The premises had not been properly maintained and some people were unable to use the bathroom and shower facilities due to a lack of suitable equipment.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Not all staff treated people with dignity and respect and people had not been involved in writing their care plans. Care plans lacked person-centred information for staff to engage people in a meaningful way and to support them to maintain hobbies and interests.

The provider did not always take responsibility to engage with other healthcare professionals to ensure people received the right care.

Medicines were managed safely, and people gave positive feedback about the staff caring for them.

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

Rating at last inspection and update
The last rating for this service was good (published 4 November 2019).

Why we inspected
We undertook this focused inspection to follow up on specific safeguarding concerns which we had received about the service. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with the maintenance of the premises and the management of the service, so we widened the scope of the inspection to become a comprehensive inspection and looked

at all five key questions.

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.

We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pearson Park 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 person-centred care, consent, safety, safeguarding, the premises, staffing and the running of the service at this inspection.

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 for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
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 timeframe. 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not caring. Details are in our caring findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Pearson Park 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
This inspection was carried out by one inspector.

Service and service type
Pearson Pare 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.

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 and we sought feedback from the local authority safeguarding team. 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 used all of this information to plan our inspection.

During the inspection

We spoke to seven people who used the service about their experience of the care provided. We spoke to eight members of staff including the provider, acting manager, senior care worker, care workers, cleaner and cook. We observed care to help us understand the experience of people who were unable to speak with us.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision.

After the inspection
We reviewed a variety of records relating to staffing and the management of the service. We also spoke to one relative about their experience of the care provided.

Inadequate

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 good. At this inspection this key question has now deteriorated 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

- Practices at the home put people at risk of avoidable harm.
- The provider did not assess the risks to people from sitting for prolonged periods of time. For example, we observed people at risk of developing pressure ulcers sat in wheelchairs for several hours without support to regularly change their position.
- Where risks associated with people's health had been identified, the provider had not acted to mitigate these risks. For example, one person did not have a care plan for managing their epilepsy.
- The provider had not made appropriate referrals to external services where people's needs had changed, to ensure they received safe care. For example, they had made changes to the care given to one person who had been receiving palliative care, without consulting with other healthcare professionals, following a change in their condition.
- The provider had not considered people's specific health and safety risks when assessing people's individual risk of contracting the COVID-19 virus. Such as, asthma or vaccination.
- The provider had not considered the health and safety of people when carrying out maintenance in the home. They had not carried out a risk assessment for work to address a leak; floorboards had been removed and tools left in an unlocked room, located close to people's bedrooms.
- Some people's equipment was not safe for use and had been used to hold open fire doors. Staff had not identified two faulty airflow mattresses. One of these mattresses belonged to a person at high risk of developing pressure ulcers; this person's bedrails had also corroded, and welded joints showed signs of wear.
- The provider did not carry out any review and/or investigation following safety-related incidents, to prevent reoccurrence and improve the safety of the service. They had not monitored reoccurring incidents, such as falls, some of which had resulted in head injuries.

Systems were either not in place or robust enough to demonstrate safety 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.

The provider took action during the inspection to repair the two faulty airflow mattresses. Following the inspection, the provider carried out a risk assessment for the maintenance work taking place.

Preventing and controlling infection

- The provider did not properly maintain the premises to ensure effective cleaning and infection prevention

and control practices.
● Surfaces were worn, paint in some people's bedrooms was peeling and the laminate flooring in the communal lounge was chipped. The faux leather exterior of one chair had disintegrated from being saturated with urine and one person's bed was left marked with faeces.

Systems were either not in place or robust enough to ensure the premises were clean. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action during the inspection to remove the damaged chair.

Systems and processes to safeguard people from the risk of abuse

● Staff neglected to meet some people's basic personal care needs. People were unkempt and wore dirty clothes.
● Local safeguarding processes were not followed in response to allegations of abuse. The provider was aware of an allegation made by one person and had implemented measures aimed at protecting staff. They had not investigated these allegations or referred the person's concerns to the local authority safeguarding team.

Systems were either not in place or robust enough to safeguard people from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Staff were rushed and did not have time to spend with people or attend to their needs.
● The provider had not reviewed staffing levels to meet the needs of service users who preferred to wake early in the morning.
● People spent long periods of time sat in communal areas, often without staff present. One person did not receive the support they needed to move around the home safely and had fallen on several occasions.
● People were not routinely supported to have baths and showers or use the toilet and relied on continence aids.
● The provider did not consider the mix of staff skills or people's specific needs as part of their calculations to determine staffing levels.

The provider had failed to deploy enough staff to meet the needs of the people they care for and support. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider carried out appropriate recruitment checks to ensure only suitable persons were employed at the service.

Using medicines safely
● Staff administered people's medicines on time and as prescribed.
● Staff offered people "as required" medicines, such as pain relief, and protocols were in place to guide them to do this.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Care and support was not based on a full assessment of people's needs and did not reflect current evidence-based guidance.
- Referrals had not been made to ensure people with specific needs received the right care and support and people may have been left in pain and/or discomfort.
- Staff did not adapt how they cared for people living with dementia. One person was moved in their wheelchair between communal areas and received little meaningful engagement from staff.
- There was no guidance for staff about how to communicate with one person, whose first language was not English, to ensure they were able to express their views and be involved in making decisions about their care.

Systems were either not in place or robust enough to ensure people' received person-centred care. This was 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 premises were not properly maintained and had not been adapted to meet the needs of people living with dementia or with specific mobility needs.
- Some people's furniture was broken, and the light in one bedroom did not work. In two communal toilets, the handles to the taps had been removed.
- Contrasting colour and signage had not been used to support people living with dementia to find their way around the home.
- People with specific mobility needs could not use the communal bath or shower due to a lack of suitable equipment, which compromised their dignity.
- The lounge was crowded, with little room for people to move freely without risk of knocking into people sat in wheelchairs and there was no space for people to spend their time engaging in different activities.

The premises were not properly maintained and had not been adapted to meet the needs of people using the service. This was a further breach of Regulation 15 (Premises and equipment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Not all staff had completed or kept up to date with the mandatory training, including safeguarding and infection and prevention control. This had been picked up through the provider's audits, but little action had been taken to address this.
● Staff did not demonstrate they had the skills to adapt the care they provided to the different people using the service. Staff were not provided with training in dementia and mental health, despite the service being registered to provide support in these specific areas.

The provider had failed to ensure staff had received suitable training to meet the needs of the people they care for and support. This was a further breach of Regulation 18 (Staffing) 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 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.

● Decisions had been made about people's care and treatment, without considering the person's views or considering the least restrictive option, in line with MCA. Such as, the use of bedrails and vaccinations.

Systems were not robust enough to ensure best interest decisions had been made in line with MCA. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recognised the role of independent advocates and engaged with other healthcare professionals where appropriate, when making specific decisions about care, for people who lacked the capacity to do this.

Supporting people to eat and drink enough to maintain a balanced diet
● The support given to people who required assistance to eat was task orientated and was not always provided in a timely way. People who required support to eat and drink had been left to do this themselves and only received help after staff had supported other people and/or completed other tasks. One relative told us their family member had to ask for support to eat and this was often rushed.
● Staff recognised people's individual dietary preferences, including people who followed a vegetarian or vegan diet.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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; Ensuring people are well treated and supported; respecting equality and diversity

- People were not cared for in a dignified way.
- People had been provided with thin, worn towels and sponges used to wash with were dirty.
- Despite some people's unkempt appearance, staff did not intervene to help people wash or get changed into clean clothes.
- A curtain, used to separate the two halves of a shared bedroom, hung over the person's bed when drawn and did not draw the full length of the room to offer complete privacy.
- There was no curtain or blind to cover a large window in the communal bathroom on the ground floor.

The provider had failed to protect people from degrading care. This was a further breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Engagement between people and staff was task orientated and not all staff treated people with dignity and respect. One staff member spoke to us about people without acknowledging them and used their pen to point at the people they were speaking about. The same staff member walked into someone's bedroom early in the morning without knocking and while they were still sleeping.
- Staff did not have the time to acknowledge or offer emotional support to people who appeared distressed. Staff did not comfort one person who was tearful and upset and another person had spent prolonged periods of time walking the length of the corridor without any engagement from staff.
- A cupboard where people's records were stored was routinely left open and we observed a newly employed cleaner look through one person's care plan.
- Despite our findings, people gave positive feedback about the staff caring for them.

Supporting people to express their views and be involved in making decisions about their care
- People told us they had not been involved in writing their care plans and a relative told us they had often not been informed about any changes in their relatives' condition.
- Staff did not always ask people's preferences. Some staff moved people in wheelchairs between communal areas without engaging with them. A staff member had attempted to move one person from the lounge into the dining room for lunch without asking them; another person informed them they had a choice about where they wanted to each lunch and did not have to eat in the dining room if they did not

want to.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

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

- Care plans contained little information about people's different interests. One person's care plan was limited to 'chatting' and taking part in specific 'house activities', such as 'throwing soft balls' and 'hula hoops'. Another person's care plan included staff buying their groceries for them.
- Activities that took place were not suitable for everyone. Staff had left one person with a microphone to sing karaoke in the lounge, despite some people not wanting to take part. This had caused some people to shout in distress. One person said, "We shouldn't have to put up with this."
- Staff did not always have enough time to engage people in meaningful activities. One person led a game of bingo, which not everyone wanted to, or were able to play. One person told us they had asked the provider if they could go for a walk in the local park and they had been told they were not allowed to. This person told is, "[I] get fed up of sitting about all day…I was nearly crying because I wanted to go in the park." Another person told us, "It's boring." A staff member told us there were not enough staff for them to support people to access areas outside of the service.

Meeting people's communication needs

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

- The provider had not taken steps to comply with AIS. There was no care plan for communication for one person living with dementia and we did not see information had been provided in format the person would be able to understand. For example, easy read or large print.

End of life care and support

- People's end of life care needs were not re-assessed regularly. The provider had not engaged with other healthcare professionals where people's needs had changed.
- There were systems and processes in place to ensure people were provided with anticipatory medicines for their symptoms.

Improving care quality in response to complaints or concerns

- The provider had a complaints policy in place which included details about external advocacy services. A relative told us a complaint they had raised with the provider about their relatives' care had been dealt with and they were satisfied with the outcome.

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 good. At this inspection this key question has now 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care

- There were widespread and significant shortfalls in the running of the service, which impacted on the care people received.
- People did not receive person-centred care and their specific needs had been routinely overlooked which put people at risk and compromised their dignity.
- Staff had not been provided with the time and resources they needed to deliver high-quality care.
- The provider had failed to implement a robust governance system to ensure proper oversight of the service. Audits were ineffective and did not identify or prompt action to address the serious concerns we found in the safety and quality of the service.
- Roles, responsibilities and accountability arrangements were not clear. The provider had delegated the task of completing audits to the office manager, who had not received any additional training to do this. The provider told us they 'glanced' at these records.
- The quality assurance arrangements in place did not evidence any opportunities for learning to improve the service and the provider did not carry out any investigations in safety-related incidents.

Systems were either not in place or not robust enough to ensure compliance with regulations. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The provider had not always taken responsibility to engage other agencies, as appropriate, to ensure people received the right care.
- The provider had offered people formal opportunities to provide feedback, including completing a satisfaction survey about their care and attending a residents meeting to discuss the running of the service.