Advinia Care Homes Limited

Parklands Court 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Parklands Court Care Home is a residential care home providing personal and nursing care to up to 163 people. The service provides support to older people, some of whom are living with dementia, people with a physical disability and younger adults. At the time of our inspection there were 55 people using the service.

Parklands Court Care Home consists of 3 purpose-built single storey buildings called Collins, Samuel and Marlborough. Each unit has access to a garden. There were several other self-contained units on the same site, but these were not in use at the time of the inspection.

People's experience of using this service and what we found
Systems used for the management of medicines were not always safe. Some people experienced delays in their care and support due to staffing not being available when they needed them. There were systems in place to try and promote learning from incidents and events, however these were not always effective.

Governance processes and quality audits had failed to drive significant improvement and the home had been rated requires improvement at the last 4 inspections. People, relatives, and staff felt communication from the provider was poor and this had negatively affected their view of the home.

Staff knew how to escalate concerns for people's safety and risks were assessed and managed to reduce the risk of harm. Improvements had been made to infection control, the home was visibly clean, and staff followed guidance to reduce the risk of cross infection.

Staff sought consent before providing care. 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.

There was a new management team in place who were open about the improvements required and were developing a plan to raise the standard of care people received.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 6 January 2023). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found although some improvements had been made the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last 6 consecutive inspections.

Why we inspected

We received concerns in relation to staffing levels and poor-quality care. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe 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 Parklands Court Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the management 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Parklands Court 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 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
The inspection was conducted by 3 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
Parklands Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Parklands Court 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, a new manager had recently started working at the service and they planned to submit an application to register.

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 work with the service. 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.

We used all this information to plan our inspection.

During the inspection
We spoke with 7 people who used the service and 7 relatives about their experience of the care provided. We spoke with 9 staff, including care staff, senior care staff and nurses. We also spoke with the deputy manager, the manager, the quality and compliance manager and the divisional director.

We reviewed a range of records, these included 16 people's care records, medicines administration records and governance and quality assurance records. We also looked at 5 staff recruitment files. 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.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. 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.

Using medicines safely

● Records relating to the management of medicines were not always accurate. On Collins unit records of medicines in stock did not always match the Medicines Administration Records (MAR). Staff were therefore not always able to confirm people had received their medicines as prescribed.
The deputy manager advised they would begin an investigation into our findings.

● On the other two units' records reflected people received their medicines as prescribed. Systems used for the administration of medicines were safe. Daily checks were carried out to ensure medicines were stored safely. Where people were prescribed controlled drugs, which have special regulations on ordering, storage, administration, and recording; we found records we checked relating to the administration and storage of these medicines were accurate.

● We observed medicines being administered and saw staff took time to explain to people what their medicines were and checked they were happy to take them. Where people required their medicines 'as required', guidance was available to staff to ensure these were given in a consistent way.

Staffing and recruitment

● We received mixed views about whether people felt staff were available when they needed them. One person said, "The staff used to have more time to stop and have a chat with me, and after 7pm you see no staff at all." Another person commented, "If I press my buzzer, I sometimes have to wait quite a long time."

● Other people and relatives we spoke with were happy with staffing levels and did not feel they had to wait for care and support. We observed staffing levels during the inspection and found staff were able to respond when people needed them. However, we shared the concerns about delays in staff response time and availability in the evenings with the management team who said they would review staffing allocations based on people's needs.

● Staff had been safely recruited. The provider had carried out pre-employment checks, including Disclosure and Barring Service (DBS) checks, to ensure staff were safe to work with people. However, we found where staff had previously worked in the health and social care sector evidence of their conduct had not always been obtained.

Learning lessons when things go wrong

● The provider had established systems in place to try and ensure learning took place following incidents and events. For example, where a fall occurred, this triggered a review which included, where relevant, a referral being made to the falls prevention team.

● However, staff we spoke with were not always aware of learning from events and told us information was

not always shared with them. This meant they may not act on any required changes. For example, where medicines audits were completed by the management team the findings were not consistently shared with staff responsible for the administration of medicines.

Systems and processes to safeguard people from the risk of abuse

● Most people told us they felt safe. One person said, "I have got my own room with all my stuff in and can lock my door if I want to…I'm glad staff are there, I have built up good rapport with some of them, they know what I like…I'm comfortable with them." Where people expressed not always feeling safe, they told us this was due to staffing levels and not being confident staff would respond in a timely way.

● Staff were aware of how to identify concerns for people's safety and records reflected concerns were escalated so that action could be taken to protect people from harm.

● The manager was aware of their responsibilities in relation to safeguarding and the management team had made referrals to the local authority and notified us, as required by law.

Assessing risk, safety monitoring and management

● Risks to people's health, safety and well-being were assessed and managed. Once a risk had been identified a plan was created which prompted staff to complete care tasks which helped maintain the person's safety. For example, where people required regular repositioning to maintain the integrity of their skin, staff were prompted to support them with this throughout the day and night.

● Staff we spoke with knew people well and understood their needs. People's health needs were documented in their care plans and guidance was provided for staff to manage any associated risks. For example, were people had diabetes or were at risk of falls, staff had information available to them to support decision making and inform their actions.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

● Staff sought consent from people before providing care and were aware where people lacked the mental capacity to make specific decisions.

Preventing and controlling infection

At the last inspection the provider had not ensured people were protected from the risk of infections through their infection control practices. This was a breach of regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had been made and the provider was no longer in breach of this regulation.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
The management team were aware of their responsibilities in relation to supporting people's rights to have visitors. Relatives and visitors told us they could access the home freely.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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 failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of regulation 17.

● Governance processes were in place and had identified some of the concerns we found at inspection. However, governance processes and quality audits had failed to drive significant improvement and the home had been rated requires improvement at the last 5 inspections.
● There was evidence of some checks and audits being carried out. However, where there were gaps in checks, for example for mattress settings. It was not always clear who had oversight of records and who was responsible for following up missed actions to ensure people's safety.
● Audits used for the management of medicines had not always been effective at identifying improvement and had not addressed the concerns we found during the inspection.

The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We discussed our concerns about the governance of the service with the manager, the divisional director and the quality and compliance manager, who had all been recently appointed. They told us they felt they had a good understanding of the areas that required their attention and improvement and were in the process of developing a plan to raise standards at the home. The divisional director told us, "We are very aware the service has to vastly improve for residents. The oversight has not been detailed enough. We feel this new team can move the home forward, we are hopeful and enthused."
● The rating from the previous inspection was displayed visibly throughout the home, as required by law.

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

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

● People and their relatives told us they did not feel involved in the changes being made at the home. People expressed concerns about a lack of consultation about their care and told us a lack of information was creating anxiety. One person told us they had asked a visiting professional for information about the changes as staff were unable to advise them.

● Staff we spoke with expressed mixed views, with some feeling supported by direct line managers and others citing a lack of support. Supervisions were reported to be 'hit and miss' and staff told us an inconsistency of management had affected their morale.

● The manager and divisional director told us they were aware communication with people, relatives and staff had not been given the priority it needed. As a new management team, they told us they had meetings booked with people and staff to discuss planned changes to the home and to listen to people's views and concerns.

● A monthly newsletter was available which described some of the activities people had taken part in and provided information about future events at the home.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager and divisional director were aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Working in partnership with others

● The staff team worked in partnership with external agencies, including healthcare professionals, social workers, and GPs to ensure people's needs were met.

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	The provider had failed to establish systems to effectively assess, monitor and improve the quality and safety of the service.

The enforcement action we took:

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