Four Seasons (JB) Limited

Park House

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: Park House is a purpose-built care home that consists of five units providing residential and nursing care for up to 111 people with varying needs including end of life and general assistance with everyday life for people living with dementia. At the time of inspection 92 people were living in the home.

People's experience of using this service: People we spoke with told us that they felt safe living in the home however, during the course of the inspection we identified serious concerns with the service.

Complaints, accidents, incidents and safeguarding processes were inadequately managed and not reported by staff either through communication channels within the home or by using the provider's electronic system. Audits of the service were ineffective and, in some cases, not carried out.

We identified that a lack of cohesive working and poor communication within the home had led to risks not being recognised and acted on.

Medicines were not managed safely and the monitoring information for people living in the home was not always completed fully. Risks were not always recognised by staff and acted on by the provider.

We saw recruitment and induction process into Park House for either permanent or agency staff was not robust. Staff had not attended training the provider required them to and there was no oversight of supervision, appraisal or induction by the provider. This placed people at risk of receiving inappropriate and unsafe care.

Parts of the internal and external environment posed a risk to people and infection control standards at the home required improvement.

People living at the home and their relatives indicated there were issues regarding staffing levels. We saw that there was a high use of agency staff and that this impacted on the quality of the care being delivered.

People told us that they felt staff respected them however, we observed behaviour that was not respectful and feedback from people living in the home was that there were few activities on offer. Confidentiality was significantly breached, this meant that the rights of people were not respected.

Rating at last inspection: The last inspection was carried out in September 2018 and was rated as Requires Improvement.

Why we inspected: This inspection was brought forward due to information of risk or concern in regard to staffing, moving and handling procedures and governance of the home.

Enforcement: The service met the characteristics of Inadequate in four key questions of safe, effective,

responsive and well-led and Requires Improvement in caring. We are taking enforcement action and will report on this when it is completed.

Follow up: We will continue to monitor the service closely and discuss ongoing concerns with the local authority.

The overall rating for Park House is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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 to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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. We will have contact with the provider following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

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? 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 responsive Details are in our Responsive findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Park House

Detailed findings

Background to this 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.

The inspection was prompted in part by concerns shared by the local authority, other professionals and members of the public surrounding staffing levels, lack of management of the home and unsafe moving and handling practices. This inspection examined those risks.

Inspection team:
This inspection was carried out by one adult social care inspector, one assistant inspector, one medicines specialist professional advisor (SPA), one nurse specialist professional advisor (SPA). An expert by experience also attended the inspection. 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: Park House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A manager was going through the processes to register with CQC. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

What we did:
Before the inspection we asked for information from the local authority and we spoke with Healthwatch Wirral for any additional information about the home. We reviewed the information we already held about the service and any feedback we had received.

During the inspection we spoke with eight people using the service and five relatives to ask about their experience of the care provided. We spoke with nine staff, deputy manager, manager and area manager. We

also received feedback from other social care professionals.

We reviewed a range of records. This included eight people's care records and medicine records. We also looked at five staff files around staff recruitment. Various records in relation to training and supervision of staff, records relating to the management of the service and a variety of policies and procedures developed and implemented by the provider

Inadequate

Is the service safe?

Our findings

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

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

- Systems and processes regarding safeguarding were ineffective. We identified instances of reported concerns that had not been recognised and acted on by the provider. The electronic database the provider had in place was ineffectual as information had not been inputted by staff, so monitoring was inadequate.
- We identified disciplinary issues regarding poor practice that had not been acted on by the provider as this information had not been passed on from staff to management.

The lack of robust systems and processes to safeguard people demonstrated breaches of Regulation 13 and 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- We identified a number of issues regarding the environment that posed a risk to people living in the home. We saw loose pipe covers allowing access to pipe work. There was one bath with a bath panel missing, one toilet was loose on the cistern and pan base and toilet seats were also loose. Additionally, we saw broken door locks and a missing radiator cover.
- The external area of the home was not well kept, examples were cigarette ends dropped on the floor just outside an exit door and debris was piled against a wooden fence. This fence went up to the main building which made it a potential fire hazard. There were trip hazards for example bags of salt and sand left in and around the patio seating which meant it was not a suitable area for people living in the home.
- Monitoring information such as charts for nutrition, fluids were not always completed fully and were at times completed at the end of the day. This meant there was a risk of information not being logged.
- People living with dementia were at risk of dehydration due to their constant preoccupation with purposeful walking throughout the day. There was no evidence that this had been identified as a risk.
- We saw that some people did not have their call bells available or in reach. This meant that there was a risk of people being unable to call for assistance if they were in need of help.
- On one unit we saw seven people without shoes on and only wearing socks. The floor was a smooth wooded surface. This was a slip hazard. We did not see evidence that this had been risk assessed.
- Quality of risk assessment and review was inconsistent throughout the five units of the home. We identified that one person's monthly mobility review had not been completed monthly. Another example was a manual handling profile completed did not match their personal evacuation plan, additionally this also did not match their main care file.
- A care plan stated 'bony areas to be regularly checked' however there was no evidence of this being carried out.

The lack of robust systems and processes to assess risk and monitor safety demonstrated a breach of

Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not always recruited safely. Concerns about people's previous conduct had not always been risk assessed. Application forms had not been fully completed and health questionnaires were not always signed and dated.
● There had been a consistent high use of agency staff for several months which meant continuity of care was not in place.

The lack of robust systems and processes regarding staffing and recruitment demonstrated a breach of Regulation 17 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely, and we identified that practice was not consistent throughout the home. We identified one person who had not received their medication for two days.
● Homely medicines were not managed safely and was not in accordance with the providers own policy. A homely remedy is a product that can be purchased (e.g. from a pharmacy or supermarket) for the relief of a minor, self-limiting ailment without the need for a prescription.
● Topical medicines (creams) were not managed safely. We identified incorrect cream being administered and the charts that were meant to be completed when topical medicines had been administered had not.
● Safe storage of medicines was not always in place. We identified that there were medicines stored in the refrigerator that did not need fridge storage. Some liquid medicines had date of opening stickers to indicate in use expiry, but practice was inconsistent throughout the five units within the home. Other medications alternative medications were left unsecured in people's rooms.
● There was inconsistent practice surrounding the administration of medicines early in the morning. Some were taking place and other were not.

The lack of robust systems and processes regarding the use of medicines within the home demonstrated an additional breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We observed inadequate infection control processes. Examples included used gloves that had been inadequately disposed of, new gloves were out of their box and a reusable urine bottle was placed on top of them potentially contaminating them.
● Some toilets did not have gloves or aprons in them. Therefore, staff did not always have appropriate access to PPE to reduce the risk of infections being spread.

The lack of robust systems and processes regarding infection control demonstrated an additional breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Due to the inadequate record keeping we could not be certain that mistakes that had happened had been identified and acted on. This meant lessons could not have been learnt to reduce the risk of repeating mistakes.

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

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience

- We asked for four staff files of new staff members and asked about their induction into the home. Only two files were provided as the others could not be found.
- The two induction records provided were inadequate. The new staff members mentors were their peers not supervisors and whole inductions had been signed off on one day. This was not effective.
- We looked at records for agency staff as the home used a high level of agency cover. Some did not have induction paperwork and others did not have their personnel overview from the agency. This meant agency staff did not have an effective introduction into the home and people's needs.
- Supervisions were not effective and were not being used appropriately. Supervision is a process that includes arranging regular and frequent meetings between a staff member and their supervisor to review their work and to provide development and support.
- Yearly appraisals held minimal information. An appraisal is a method by which the job performance of an employee is documented and evaluated. This had not happened.
- On speaking to staff there was a lack of underpinning knowledge about supporting people living with dementia. Examples included people who constantly walked with purpose need their fluids monitoring as they use a lot more energy, this was not planned for. Also, keys for fire extinguisher boxes were not kept in the allocated area we were told that this was due to 'dementia'.
- We asked the area manager for the training information for the staff. Two documents were provided one for 'essential course compliance' and one for 'additional training'. We saw that in all areas there was poor compliance.

The lack of robust systems and processes regarding staff support, training and induction demonstrated a breach of Regulation 17 and 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- The home had five units. One dementia residential, one general nursing, two dementia nursing units and one residential unit.
- The general presentation of the home was in places poorly maintained with chipped paint and one entrance to a unit gave an institutional feeling. This was discussed with the new manager. Doors to people's rooms were poorly maintained and did not all have name tags.
- Some bathrooms had a persistent bad smell in them that indicated an issue with drains.
- The initial entrance to the home was bright however when we went through to use the lift and/or speak to

the manager this led immediately into a utility area that was not welcoming.
● Some units did not have wall decoration in the corridors so gave a stark impression.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw that assessments of people's needs had taken place however, due to the identified issues with documentation we could not be certain that appropriate expected outcomes were identified, and that care and support was reviewed when required.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● We looked at the electronic system the provider had in place that was meant to monitor incidents such as weight loss. However, we could not be certain that appropriate actions had been taken as it did not inform whether other professionals had been contacted appropriately. For instance, one person had significant weight loss five months previously but there was no evidence a referral had been submitted to dietetic services. Another person who had experienced weight loss had been referred to a GP however there was no evidence of dietetic referrals.
● People said that they enjoyed the food provided.
● We spoke with the chef on duty who told us how any specific diets, allergies or preferences were recorded when people were admitted into the home and any changes made appropriately on a regular basis. These were displayed in the kitchen.
● We ate lunch with people on one unit. The tables were set with cloths, cutlery and paper napkins but there were no condiments or sauces, and none were offered to people.
● On another unit we saw that two different weekly menus were displayed on a wall. We asked which one was for that week as there was no indication for people which one was correct. We did not see a daily menu.

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 with appropriate legal authority. 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 any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Ensuring consent to care and treatment in line with law and guidance
● We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met and concluded that they were.

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

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us that privacy was available if they wanted to visit.
- People we spoke to felt staff supported them to be as independent as possible and relatives we spoke with felt this was done as much as was able.
- People we spoke with said that staff for the most part knew them quite well and were caring in their approach, however we identified concerns with inaccessible call bells, poor complaint handling and medication issues.
- People we spoke with said that staff respected their privacy however, during the course of the inspection we observed this was not always respected. Examples were not knocking on doors before entering a person's bedroom and loudly telling a person in a corridor that they were helping them access the toilet.
- Most of the relatives we spoke with said their family member was treated with dignity and respect. However, we observed that some people living in the home appeared unkempt.
- During the course of the inspection, we were aware of a number of incidences that were not recorded, reported or potentially responded to safely and appropriately. We identified times that people's privacy and dignity was not respected. This meant that staff working at the home did not always recognise people's diversity. There were occasions where staff had not responded to people's needs or provided appropriate information or support. This potentially impacted on the wellbeing of people living in the home.
- We identified that confidentiality had not been respected by the staff and the provider, this immediately brought this to the attention of the new manager and area manager for action.

The lack of processes to ensure people's dignity, privacy, equality and diversity was respected demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

- People we spoke with told us that they had not been involved in their care plan or any meetings. One relative told us "We have read the care plan but don't feel sufficiently informed."
- The provider used an electronic form for people to give feedback on the service, this was available at all times by using an electronic tablet that was positioned at the entrance of the home.
- Only one of the people we spoke with reported doing a questionnaire last year, however, they didn't get any feedback. None of the people we spoke with knew about any residents' meetings.

Inadequate

Is the service responsive?

Our findings

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

Services were not planned or delivered in ways that met people's needs. Some regulations were not met.

Improving care quality in response to complaints or concerns

- We asked people and their families if they felt they could raise any concerns with staff and management and received mixed feedback.
- Complaints had not been managed appropriately. We found serious complaints had been made to senior staff however they had not been dealt with appropriately as the had report just been left in a file. There was no response and no outcome.
- We identified the mismanagement of one complaint that had led to a significant breach of confidentiality. These were immediately brought to the area manager, new manager and deputy managers attention.

The lack of effective processes regarding complaints demonstrated breaches of Regulation 16 and 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- The provider employed activities co-ordinators. However, feedback from people living in the home was that there were few activities on offer. We observed some people sitting alone at tables and in several lounges the television was on in the morning and afternoon, but no one appeared to be watching it. We were told that the activities coordinators only worked on specific units and did not cover for each other.
- We were told that the care staff organised activities when the activities co-ordinator was not in the home however did not see any evidence of staff organising anything.
- We were told by one relative how a staff member had come to ask about the persons interests however it was now 'to late' to ask as the person had now deteriorated and the time to ask should have been earlier, for instance when the person had moved into the home.
- Some of the people and family we spoke with told us that they were not involved in care plans. This meant some people did not have choice and control.
- People's care plans that we looked at included information about the individual, such as their communication methods, health, emotional, and physical health needs. However, the quality of the care files varied between units. Some files held information from two years previous and made current information hard to find. As the provider used a high level of agency staff this meant that we could not be certain that staff were able to get the correct information to support people safely.

The lack of robust processes to ensure care was personalised and able to meet people's needs effectively demonstrated a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● We saw advance care planning in place and the provider was signed up to the 'Six Steps pathway'. The pathway leads from initial discussion about death and future care, on to assessment and the provision of high-quality co-ordinated care and support through to the final days and end of life.

● We noted on the on people's 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms that doctors had signed these, however we did not see either confirmation where the person had capacity or family members signature to state they understood and gave consent for the DNACPR to be in place. This was not in line with relevant guidance

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

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.

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

- The provider had employed a new manager and deputy manager who had been in post for a short time and who were starting to improve systems and processes. There had been a significant lack of leadership within Park House and a lack of understanding about roles and responsibilities.
- Audits were not effective due to issues we identified with medications, accidents and incidents and complaints. Additionally, audits were not useful as staff were not reporting or recording on the providers electronic monitoring system correctly or at all. We identified aspects of the medication audit that was not a true account as staff had inputted obviously incorrect information. This was highlighted to the provider.
- Other audits were not in place, for instance monitoring information such as turn charts and nutrition and fluid charts.
- There was no oversight of the premises, infection control and external environment.
- There had been no oversight of the recruitment, induction/supervision process and we could not be certain people's practice was otherwise monitored.
- We identified that there was a lack of communication between management and staff that led to accidents, incidents and complaints being responded to inappropriately or not at all.
- As there have been safeguarding's, accidents and incidents that had occurred that the provider, manager and deputy were not aware of, notification requirements have not been met.
- The findings of the inspection identified a lack of cohesive working with the home as we identified that there was some disconnect between the five units in the home concerning how each of the units work and also regarding staff knowledge.
- Management of confidentiality was inadequate. We identified a serious breach of confidentiality that was immediately brought to the providers attention.

This demonstrates a breach of Regulation 17 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

- We identified throughout the inspection where information had not been passed on within the home.
- Due to the inadequate record keeping and reporting systems we could not be certain that the provider had worked in partnership appropriately with other professionals.

● Feedback we received from relatives indicated that communication was not always effective.

Continuous learning and improving care

● As the audits were ineffectual there was no evidence that any mistakes had resulted in any learning and so care was not improved.