Parklands Care Services Limited

Wyndthorpe Hall & Gardens 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
Wyndthorpe Hall & Gardens Care Home is a residential care home registered to provide personal and nursing care for to up to 82 people. Some people using the service were living with dementia. The home had two separate buildings, Wyndthorpe Hall and Court and Wyndthorpe Gardens, each with a registered manager. Wyndthorpe Hall and Court provides residential dementia care and Wyndthorpe Gardens provides nursing dementia care. At the time of our inspection there were 54 people using the service.

People's experience of using this service and what we found
The provider had made some improvements following the last inspection. This inspection identified that the provider required continued improvement.

The systems in place that promoted safety through the layout and hygiene practices of the care environment were not effective.

Medicines were generally managed safely but the provider could share knowledge and learning across the different elements of the service to improve consistency. We made a recommendation about this.

People were safeguarded from abuse. Staff were able to describe the process for reporting safeguarding concerns. People and their relatives told us that they felt safe at Wyndthorpe Hall and Gardens.

There were enough staff on duty to provide care and support to people. Staff demonstrated care and compassionate when they supported people.

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.

Management oversight and leadership was not effective and there were gaps in management audits and checks. For example, daily management reviews of the care environment had not picked up some aspects of care that were not person-centred.

Following the last inspection, the provider had appointed a compliance and support manager who had started to make changes and improvements to the care planning and management audit systems.

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 19 December 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 improvements had been made and the provider was no longer in breach of regulation 15 of the Health and Social Care Act 2014. However, we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last 2 consecutive inspections.

Why we inspected
We carried out an unannounced focused inspection of this service on 14 September 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, premises and equipment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions safe and well-led which contain those requirements.

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 improvements. The overall rating for the service has remained requires improvement based on the findings of this inspection. Please see the safe and well-led sections of this 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 Wyndthorpe Hall and Gardens on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified breaches in relation to the cleanliness of the premises and the leadership of the service in this inspection. We have made a recommendation about how the provider could encourage its staff to share knowledge and learning about managing medicines.

Please see the action we have told the provider to take at the end of this report.

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

The 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.

Wyndthorpe Hall & Gardens 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 carried out by 2 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
Wyndthorpe Hall and Gardens 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. Wyndthorpe Hall and Gardens 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 the service had 2 registered managers in post. 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 inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and sought feedback from the local authority and local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people and 2 relatives about their experience of the care provided. We spoke with the 2 registered managers, the compliance and support manager for the organisation, the deputy manager and 5 members of staff from the care, administration and maintenance teams. We reviewed a selection of records which included 4 people's care records and 4 staff recruitment files. We reviewed a range of medication records in each of the buildings and looked at a variety of records relating to the management of the service.

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.

Preventing and controlling infection

At our last inspection the provider had failed to ensure infection, prevention and control policies and procedures were followed and ensure the home was clean. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- The hair dressing rooms in both Wyndthorpe Hall and Court and Wyndthorpe Gardens were not clean. The taps and shower attachments were dirty and there was evidence of limescale.
- A bedroom in Wyndthorpe Gardens had a floor covering that was extremely sticky. Every time anyone took a step there was a loud 'unsticking' noise. It was not clear what had made the floor sticky or whether it had been cleaned appropriately.
- There were gaps in temperature monitoring record for fridges in dining rooms and jugs of juice in the fridges were not dated. On the day of inspection the temperature of one of the fridges was 12c which is above the maximum temperature for safe storage of food and drinks. All food and drink items were disposed of and the fridge was marked out of order.

The provider had failed to ensure infection, prevention and control policies and procedures were followed and ensure the home was clean. This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- 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 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 provider supported and enabled visits for people living at the home to maintain contact with family and friends.

Using medicines safely
● Medicines were managed safely but paperwork for people's as and when (PRN) medication could have been better organised.
● There were some gaps in the medicines fridge records which had not been identified by the registered manager.
● There was a methodical and well-organised approach to medications in the nurse-led dementia unit.

We recommend the provider consider opportunities for sharing knowledge, learning and support between the nurse-led dementia and the carer-led residential units to ensure staff work effectively with each other and their managers to share the responsibility for giving medicines to people.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure the premises was properly maintained. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● The provider carried out checks of the safety of premises. This included checking electrical and gas safety and ensuring the fire alarm was checked regularly. There were suitable personal evacuation plans in place to outline the support people would need to evacuate in the event of an emergency.
● People's individual risks were assessed and care plans included the risk reduction measures required to help keep people safe. Where people were at risk of choking their risk assessment identified the need for observation and monitoring during mealtimes.
● Equipment including bath lifts and hoists had been LOLER checked and tested by an independent organisation.

Systems and processes to safeguard people from the risk of abuse
● People were safeguarded from the risk of harm and abuse.
● Policies and procedures were in place for staff to follow to report any safeguarding concerns. Staff had received appropriate safeguarding training and were aware of how and when concerns should be raised.
● When asked if they felt safe, one person told us, "Oh yes, because they all look after us. Nobody comes in that shouldn't come in.'

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.

Staffing and recruitment

● Staff were recruited safely and checks were carried out before staff started work. These included taking up references and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● People were complimentary about the staff. One person told us, "They are all quite professional. I must say they are all very nice."

● We observed that staff were caring, compassionate and thoughtful in their care and support for people who lived at Wyndthorpe Hall and Gardens.

● Feedback from staff about morale was mixed. Some staff indicated morale was low and others told us it was 'ok' but could be improved with support.

Learning lessons when things go wrong

● Accidents, incidents and safeguarding referrals were reviewed and analysed. Lessons learned were identified but there were long gaps of up to 6 weeks between lessons learned being identified and subsequent feedback to staff.

● Lessons learned, reviews and audits were discussed at management meetings with the group compliance and support manager.

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

At our last inspection the provider had failed to ensure effective management oversight and governance arrangements which meant people were at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008.

Although some improvement had been made following our last inspection, we found further improvement was required and the provider was still breach of regulation 17. This is the second consecutive inspection when the provider has been rated as requires improvement in both safe and well-led.

- Daily management walkrounds and audits were not completed effectively and had not identified that people's named personal items, care products and medicated lotions were stored in bathrooms, toilets and drawers.
- Water temperature checks, shower head cleaning and fridge temperature records had not been completed consistently and the registered manager had signed to indicate they had checked that all the information was correct.
- There was an ineffective and incomplete risk assessment for legionella. The last independent legionella check was completed in July 2021.
- Systems had not identified all of the shortfalls we found during this inspection.

The provider had failed to ensure effective management oversight and governance arrangements which meant people were at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008

- In response to the outcome of the last inspection the provider had appointed a compliance and support manager.
- The compliance and support manager had introduced a software package for care plans and daily care notes. There was a plan in place to support the transition from paper records to electronic records.
- We saw evidence that new systems, audits and checks had been introduced to Wyndthorpe Hall and Gardens by the compliance and support manager but had not yet been fully implemented at the time of

inspection.

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 registered managers were aware of and understood their responsibilities under the duty of candour 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.

● Staff told us that they felt able to raise concerns and suggestions with managers but they did not feel that changes happened as a result.

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

● There had been a recent engagement exercise with relatives and family members but the analysis of the information had not been completed at the time of inspection.

● Plans were in place to use the new electronic care information system to engage with people in a dementia-friendly way.

● We were assured that the provider was on an improvement journey but had not made all the required improvements at the time of this inspection.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure infection, prevention and control policies and procedures were followed and ensure the home was clean. This was a breach of regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure effective management oversight and governance arrangements which meant people were at risk of harm. This was a breach of regulation 17(2)(a)(b) of the Health and Social Care Act 2008