

Care UK Community Partnerships Ltd

Stanley Park

Inspection report

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16 May 2023

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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

Stanley Park is a care home providing accommodation and personal and nursing care to up to 71 older people, including people who may live with dementia, or a dementia related condition. At the time of our inspection there were 61 people using the service living in one adapted building.

People's experience of using this service and what we found

A quality assurance system was in place, but it needed to become more robust to assess the standards of care in the service. Improvements were needed to the running of the service to ensure people were the main focus of care delivery and they received person-centred care.

Care was task-centred rather than person-centred. Due to staff being busy they did not have time to spend with people. Throughout our observations some people sat silently or were not engaged or stimulated.

An infection control system was in place. However, not all areas of the home were well-maintained and there were signs of wear and tear. The provider was monitoring the use of Personal Protective Equipment (PPE) for effectiveness and people's safety.

Records provided some guidance to assist staff to deliver care and support to meet people's needs. We discussed care plans should be more person-centred detailing how staff were to provide care in the way the person wanted and needed support to be provided. Risks were assessed and mitigated to keep people safe. Staff recruitment was carried out safely and effectively.

Medicines were mostly managed safely. Medicines records required more information for the use of 'when required' medicines.

There was evidence of collaborative working and communication with other professionals to help meet people's needs.

People and relatives had opportunities to give feedback about the service.

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.

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

Enforcement and Recommendations

We have identified a breach in relation to good governance at this inspection. We have made recommendations about staffing levels and staff deployment, refurbishment of the environment and

environmental design and person-centred care.

Rating at last inspection

The last rating for this service was good (published September 2017).

Why we inspected

This inspection was prompted by a review of the information we held about this service.

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 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 changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stanley Park on our website at www.cqc.org.uk.

Follow up

We have requested an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Stanley Park

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 1 inspector and 1 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

Stanley Park 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. Stanley Park 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 a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 16 May 2023 and ended on 1 June 2023. We visited the service on 16 May 2023.

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. 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

During the inspection we spoke with 16 people who used the service about their experience of the care provided and 8 relatives. We spoke with 12 members of staff including the registered manager, deputy manager, 1 nurse, 5 care workers including 2 senior care workers, 1 domestic member of staff and 1 maintenance person.

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.

We reviewed a range of records. This included 4 people's care records and multiple medicines records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including training information and policies and procedures were reviewed.

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 good. At this inspection the rating has changed to 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.

Staffing and recruitment

- There were insufficient staff and staff were not appropriately deployed to support people in a safe, timely and person-centred way. People and relative's comments included, "There are never enough staff in this place. They seem to disappear round corners", "The staff do their best but there are just not enough of them", "Staff all seem nice down here although they're very busy", "There are not enough staff to watch over people. [Name] would not have hurt their foot if they had their shoes on" and "Earlier on I was looking for someone to stop a person who kept going into the fridge, but there were no staff to be seen."
- Staff were not effectively deployed to meet all people's social and emotional needs and provide care in a timely and meaningful way. One person told us, "They [Staff] are kind enough but they don't have enough time to do everything that needs to be done" and "I can't remember staff names, but they don't listen when I tell them about things, so I don't talk with them."
- Care was task-centred rather than person-centred. People were not all engaged or stimulated. A relative commented, "Have you seen anyone apart from us talking to the other residents? The residents have been desperate for a drink, so we have been bringing them round. No drinks trolley again." Self-service snack and hydration stations were available on both floors of the home, but most people were unable to access these without support.
- We discussed these comments with the registered manager who told us a dependency tool was used to calculate the number of staff required. However, throughout the day staff appeared busy, and did not have time to interact with people, except when they provided care. We received information from the registered manager after the inspection that staffing levels had been addressed and agency staff were being used until additional staff were recruited.

We recommend the provider continues to keep staffing levels and staff deployment under review to ensure people receive safe, timely and person-centred care.

- The provider had processes in place to ensure the safe recruitment of staff and these had been correctly followed.

Preventing and controlling infection

- An infection control system was in place. However, not all areas of the home were well-maintained, and there were some signs of wear and tear to the premises. There was an odour to some areas of the home.

We recommend the provider continues with a timely programme of refurbishment to maintain the environment and an appropriate level of hygiene.

- Staff had received training in infection control practices and used personal protective equipment (PPE) effectively and safely.

Visiting in care homes

- There were no restrictions to visiting and the provider followed guidance if an outbreak was to occur.

Assessing risk, safety monitoring and management

- Risks were managed to ensure people were kept safe and staff took action to mitigate the risk of avoidable harm. A relative commented, "[Name] is a lot safer here than when they were at home."
- Care plans contained some explanations of the measures for staff to follow to keep people safe, including how to respond when people became distressed. We discussed care plans should contain more guidance for staff about how to de-escalate and reassure a person if they became upset, and when to use 'when required' medicines, where prescribed, as a last resort.
- Staff managed the safety of the living environment and equipment in it through checks and action to minimise risk.

Using medicines safely

- Medicines were mostly managed safely.
- People were supported by staff who followed systems and processes to prescribe, administer and store medicines safely. Audits identified where improvements were required.
- Medicines risk assessments and associated care plans were in place that were person specific. Protocols for the use of 'when required' medicines were not all available for people, where they had been prescribed.
- People received support from staff to make their own decisions about medicines wherever possible.

Learning lessons when things go wrong

- Lessons were learned, and aspects of service provision were improved as a result of the learning.
- Any accidents or incidents were recorded and monitored. Reports were analysed, enabling any safety concerns to be acted upon.

Systems and processes to safeguard people from the risk of abuse

- Systems were in place to safeguard people from the risk of abuse.
- Staff understood how to safeguard people from the risk of abuse. They said they would raise any concerns and were confident the registered manager would respond appropriately.
- Safeguarding concerns were reported and investigated with appropriate action taken to minimise any future risk of abuse.

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. Any conditions related to DoLS

authorisations were being met.

- Staff understood and followed the principles of the MCA. This included supporting people to make their own decisions and assuming capacity unless they thought otherwise.
- Mental capacity assessments were completed as required. Records showed if any restrictions were in place, so they were not unnecessarily applied to restrict people's choices.
- People's legal rights were upheld. Some people were subject to court of protection orders, as they did not have capacity to make decisions about their care and treatment.
- People and their representatives were involved in decisions about care provided. Where people lacked capacity, best interest decisions had been made appropriately.

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 good. At this inspection the rating has changed to 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

- The service was not always well-led.
- A quality assurance process was in place. Audits were completed to monitor service provision. However, the audit and governance processes had either failed to identify or they had not been actioned in a timely way. The deficits identified at inspection included: staffing and staff deployment, person-centred care, good governance, care and medicines records, including protocols for the use of 'when required' medicines, infection control and the environment.

The provider did not have effective systems in place to effectively monitor and improve the quality of the service to ensure positive outcomes for people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Not all systems promoted a positive, person-centred culture to benefit people living at the service.
- The premises were not all "enabling" to promote people's independence, and involvement. There was little visual and sensory stimulation to help maintain the involvement and orientation of people who lived with a dementia as they moved around.
- People were not always listened to, engaged with, and they did not all receive person-centred care. This is reported on in the safe key question of the report.

We recommend the provider ensures systems are in place to promote a culture where all people are respected and receive person-centred care, including following best practice guidance to ensure the appropriate environmental design to meet the needs of people who use the service.

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

- People, relatives and staff were asked for their feedback to allow the provider to find ways to improve the level of support provided to people. A relative told us, "Meetings take place, but I can't always attend."
- Staff said they were supported and received opportunities for training and development. People, relatives

and staff all said the manager was approachable. A relative commented, "Oh yes she is lovely [the Manager]."

- Staff and most relatives told us communication was effective to ensure they were kept up-to date about people's changing needs. A relative told us, "They [staff] ring me all the time to tell me what [Name]'s been up to."

Continuous learning and improving care; Working in partnership with others

- There was a programme of staff training to ensure staff were skilled and competent.
- Staff communicated with a range of professionals to ensure that people's needs were considered and understood so that they could access the support they needed.

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 management team understood the duty of candour responsibility, a set of expectations about being open and transparent when things go wrong.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered person failed to ensure effective systems were in place to monitor the quality of care people received. Regulation 17(2)(a)(b)