Viewpark Care Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 23 November 2016. It was unannounced, which meant the service did not know we were coming.

The previous inspection took place on 29 June 2015. At that inspection we found breaches of six regulations. The concerns we identified were as follows: The controlled drugs cabinet was not made of the right material and was not affixed to a solid wall. The service had not reported the outcome of Deprivation of Liberty Safeguards (DoLS) applications. Confidential information about people was not being kept securely. Care files were disorganised and did not ensure people's needs could be understood. The service had failed to submit notification of three allegations of abuse and several serious injuries. There was not an effective system of audit of care files and medication.

The registered manager submitted an action plan stating how the service would become compliant in those areas. At this inspection we checked whether the service was now complying with the relevant regulations.

Viewpark Care Home Limited ('Viewpark') is a purpose built residential care home registered to provide care and support to 27 older people. There were 25 people living in the home on the day of our inspection. The bedrooms are on two floors, with two lifts and two staircases. There are two dining rooms, three lounges, and a conservatory. The home is situated in a residential area of Moston in north Manchester.

The service had a registered manager who had been in post since September 2013 and became registered in June 2014. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at the management of medicines. We found that medicine storage fridge temperatures had not been recorded for three months. We found a number of errors relating to the recording of medicines, which indicated that people might not have received the correct doses. This was a breach of the regulation relating to the management of medicines.

Most staff had received training in safeguarding and understood the principles involved. We discovered a potentially serious safeguarding incident had not been recorded, and had not been reported to the local safeguarding authority. This was a breach of the regulation relating to responding to incidents of abuse or alleged abuse.

Staffing levels during the day were affected by the absence of a cook. We learnt of other recent occasions when the number of staff on duty had been reduced. There were two staff on duty at night and we found evidence of occasions when this was insufficient to safely meet the needs of people who used the service. We found there was a breach of the regulation regarding having sufficient staff on duty.

We have made a recommendation about analysing and learning from accidents and incidents.

Recruitment procedures were in place to ensure suitable staff were employed. There were cleaners on duty but we saw examples where the level of cleanliness could have been better. There had been an outbreak of a sickness bug in October 2016 but this could not be attributed to poor infection control.

The heating had been unreliable but was being fixed. There was routine maintenance of the building and equipment. There were systems to reduce the risk from fire although the register of evacuation plans required to be updated.

Staff had knowledge of the Mental Capacity Act 2005 (MCA) and we saw examples of them asking for consent before providing care. Mental capacity assessments were used although they needed to be used for specific decisions rather than as a blanket test of capacity. Best interests decisions had been made but not in every case. Letters were on file from GPs authorising covert medicines without a recorded best interests decision. However, the registered manager told us no covert medicines were currently being administered.

The registered manager had previously notified us about Deprivation of Liberty Safeguards (DoLS) authorisations. We saw one person required a DoLS application to be made, but this had not been done. This was a breach of the regulation relating to depriving people of their liberty without lawful authority.

There was no cook on the day of our visit. Lunch was a cooked breakfast, and tea was fish and chips from a local takeaway.

People were being weighed regularly but the results were not analysed to identify any risks associated with weight loss. This was a breach of the regulation relating to assessing risks to the safety of people living in the home.

Training was undertaken and we saw evidence of ongoing training courses. Staff had supervisions with the deputy manager but appraisals were overdue.

We have made a recommendation that the provider should research ways to improve the physical environment for people living with dementia.

People living in the home and their relatives were appreciative of the care provided. We saw some kind interactions between staff and people. However we also saw several examples of a lack of respect and where people's dignity was not being maintained.

Some inappropriate language about people was used, including in care plans. In some respects people's independence was limited. These examples were a breach of the regulation relating to treating people with dignity and respect.

The confidentiality of documents had improved since the last inspection.

We looked at care records. They contained an "All about me" document but they had not all been completed. Other parts of the care plans did not provide enough guidance to staff on how to meet people's needs. Reviews of care plans were sporadic and had not identified and addressed the lack of detail about how staff should meet people's needs.

One person who had recently arrived in the home did not have a proper care plan, although there were

some notes about them. We found a breach of the regulation relating to assessing people's needs and designing care to meet them.

Not all significant events had been recorded and there was no evidence appropriate referrals to health professional had been made. This was a breach of the regulation relating to keeping records.

There was no activities organiser in post, but we were told there had been one until three months prior to our inspection. Very few activities were taking place, although there were some dolls available which can be therapeutic for people living with dementia.

The lack of activities was a further breach of the regulation relating to meeting people's needs.

A survey was available for families to complete. Meetings were held for people living in the home to express their views. No formal complaints had been received within the past year.

The rating from our last inspection was not being displayed in the home, which was a breach of the relevant regulation.

Medication audits were not reliable because the answers were duplicated from one audit to the next. Care plan audits lacked depth and had not been improved since our last inspection. This was a breach of the regulation regarding assessing and monitoring the quality of the service.

Staff expressed to us concerns about the support they received from management. Staff morale was low. Although we did not discern any impact on the people living in the home, we were concerned that it might have an impact unless morale improved. The last all staff meeting had been six months earlier.

The registered manager had reported notifiable events to the CQC.

We found breaches of seven regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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.

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.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The recording of the administration of medicines was poor. Fridge temperatures had not been recorded.

There had been an incident which should have been reported to the safeguarding authority which the registered manager and provider had failed to do.

Staffing levels were not always sufficient, both by day and night.

Is the service effective?

Requires Improvement

The service was not always effective.

The staff were using the Mental Capacity Act 2005 but not always correctly. Best interests decisions were made. In one case we found an application under the Deprivation of Liberty Safeguards ought to have been made.

Staff received training and supervision to support them in their work.

The environment could be made more suitable for people living with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

People were positive about the care they received, but we saw varied examples of a lack of respect and a failure to maintain dignity.

The language used about people in care plans was not always appropriate.

Confidential documents were kept securely.

Is the service responsive?

Inadequate

The service was not responsive.

Care plans were lacking in detail about how to meet people's needs.
One person who had recently moved in did not have an adequate care plan.
Contemporaneous records were not always kept.

There were few activities and currently no oversight of any programme of activities for people to have their social and emotional needs met.

There was an opportunity for relatives to give feedback. No formal complaints had been received recently.

Is the service well-led?

Inadequate

The service was not well led.

The rating of our previous inspection was not displayed as is required by regulations.

Medication audits and care plan audits were not fit for purpose and had not identified the shortfalls we found at this inspection.

Staff morale was low and staff felt a lack of support from the registered manager and deputy manager.

Events were being reported to the CQC as required.

Viewpark Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 23 November 2016 and was unannounced. The inspection team comprised an Inspection Manager, an Inspector and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of care service. On this occasion the expert by experience had personal experience of supporting older people.

Before the inspection, the registered manager submitted a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us under the regulations.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits. They told us their last visit earlier in November 2016 had not raised any significant concerns. We also contacted a specialist health protection nurse who had visited Viewpark recently. We also saw a report of a validation visit by an officer of Manchester City Council in August 2016 assessing the home for the 'Bronze silver gold' award. This is a method of validation of quality by the Council.

We contacted Healthwatch Manchester, who did not have any information about the home. We obtained an infection control report following a visit on 11 April 2016 by the Community Infection Control Team of Manchester City Council.

During the inspection we looked around the building and observed mealtimes and interaction between staff and people living in the home. We carried out an observation known as a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who cannot easily express their views to us.

We talked or communicated with 17 people using the service, and spoke with five visiting relatives, nine members of staff, and one visiting professional. We also spoke with the registered manager and the deputy manager. We also spoke with a number of staff by telephone.

We looked at five care records in detail, medicine administration records, three staff files, staff rotas for the month of our inspection and records relating to maintenance of the building and the management of the service.

Inadequate

Is the service safe?

Our findings

We looked at the ordering, storage and administration of medicines to determine whether they were safe. We saw that following the last inspection a suitable cabinet for storing controlled drugs had been obtained. We checked the register of controlled drugs and found no errors. However, we saw that temperatures in the medicines storage fridge had not been recorded since 22 August 2016. Staff we spoke with knew how to check the temperatures but had not recorded them. It is important to ensure that medicines which need to be refrigerated are kept at the right temperature, and to record the fridge temperature to demonstrate that medicines are stored safely and remain effective.

We saw that the member of staff administering medicine was wearing a red tabard which indicated that they should not be distracted. We heard them clearly explaining to each person what the medicine was for, which was good practice. We saw that medicine administration records (MARs) were kept and that staff recorded after administering each medicine, as is the correct procedure. However, we found that the amounts of medicines recorded as given on the MARs did not tally with the quantities of medicines still remaining. For example one person was receiving Warfarin tablets. This is an anti-coagulation treatment that needs careful management and regular review to ensure people who use this medicine are supported safely. The MAR recorded there had been 56 1mg tablets in stock at the start of the four week cycle. The MAR showed that 20 of these tablets had been signed for as given. That meant there should have been 36 tablets left in stock, but we counted 44. The person was prescribed a higher dose of 3mg at weekends, but the amount of these left in stock also did not match the MAR. This meant we could not be sure that the person had been receiving the correct doses of Warfarin.

We also saw that the number of tablets remaining of an anticoagulant did not match the number recorded as given on the person's MAR. Again, this meant that the person may not have received the doses recorded on their MAR. We also saw that some medicines had been refused that morning and placed in a pot in the medicines cupboard. We were told they would be returned to the pharmacy for disposal. However, when we checked the relevant MAR we saw that these medicines had been signed for as administered to the person. This meant that the MAR was not an accurate record.

Another person had been prescribed an antibiotic. The MAR recorded that they had been receiving 10 ml doses three times a day, as prescribed. However, the quantity remaining in the bottle was 60 ml more than it should have been according to the MAR. This meant either that incorrect amounts had been given or that six doses had been missed but signed for as administered. There was a similar discrepancy with someone else who was receiving an antibiotic in capsule form; there were four capsules left in the packet but according to the MAR there should only have been two. It is important with antibiotics that people receive all the correct doses for them to work effectively.

Another person's MAR recorded that they were prescribed a painkiller to be taken 'as required'. The MAR recorded it had not been available for three days the previous week. This meant they had been at risk of not having their pain relieved. The same person had received it on the morning of our visit, at an unrecorded time, and received it again at 12.15pm. We observed medicines were being administered after 9 am on the

morning of our inspection. There should be a four hour gap between doses of this medicine, but as the time of administration was not recorded there was no way of ensuring that this happened. Another person's MAR showed the wrong number of Butrans patches in stock, although the controlled drugs register did show the right amount.

The multiple inaccuracies on MAR sheets showed there was not a reliable method of recording the administration of medicines. In addition was the failure to record fridge temperatures, and the failure to ensure medicines were always available. These failings were a breach of Regulation 12(1) and 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The record of training showed that most staff had received training in safeguarding, but there were some gaps. Some staff told us they had not received the training while at Viewpark even though the record showed they had. They told us they would refer to the procedure on the wall in the staff room about what to do with an allegation of abuse. We checked this procedure and saw that it set out the basic information. Staff told us they would always report any abuse or suspicion of abuse, either to the registered manager or direct to the CQC. The registered manager had reported five incidents to us since the last inspection. She retained a file of completed notifications but did not also retain copies of safeguarding alerts made by telephone or sent to the council.

We were, however, not confident that all safeguarding incidents had been reported to us. Prior to the inspection we had been made aware of an incident when one person living in the home had walked out unobserved and was found, by chance, by an off duty member of staff about a quarter of a mile away. At the inspection we checked this person's care plan, 'client behaviour chart' and daily notes for the relevant period, but found no reference to the incident. Several staff, however, confirmed that it had happened, and the registered manager recalled the events. This person was living with dementia and was at risk if walking out alone. The fact they were able to leave the premises unobserved constituted possible neglect, and therefore should have been reported to both the local council and to the CQC as a safeguarding incident. The failure to identify the incident as a safeguarding incident and to report it to the council was a breach of Regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were four staff on duty during the day and two at night. The registered manager told us these were the regular staffing levels and we confirmed this from the rota. Staff also confirmed that these were the usual numbers of staff on duty. There were four staff on duty when we arrived at 8.45am. However, there was no cook working. We learnt one of the two cooks had left on 9 November 2016. This meant that on some days staff had to fill in. The care staff were having to make breakfast in addition to their normal tasks. The result was that they were over-stretched. This was evident because a district nurse who was there before we arrived was kept waiting for twenty minutes. They told us staff were too busy to ensure the person they had come to see was ready.

We were informed a new cook had been appointed and was due to start in mid-December. In the meantime the absence of a cook at breakfast meant that there was in effect one less member of staff available. The staffing level could have been maintained by deploying one more care worker. The manager and deputy manager made lunch, and tea was takeaway fish and chips, so the absence of a cook did not impact on staffing levels for the rest of the day.

We had concerns about the level of staffing at night. This was an issue in our previous inspection report at a time when the service was reducing the level from three to two night staff. There we had noted staff concerns that two staff might not be enough, but noted "in the minutes of a senior staff meeting on 16 June 2015 that the provider had refused the suggestion of having another member of staff on night duty each

night of the week." At that point the plan was to introduce extra shifts of one staff up to 11pm and one staff from 5am. This had not been continued. Due to further concerns raised recently, one of the senior care workers had worked two or three nights in order to assess whether a third night staff was needed. The registered manager told us that it remained the provider's policy to have two staff at night, except when someone was nearing the end of life, when an additional member of staff would be made available if needed.

We spoke to several night staff during the inspection. They told us that on quiet nights two staff were sufficient, but that if something happened two staff were struggling. They gave an example of needing two staff to operate a hoist which some people needed. While they were doing that they could not respond if someone else pulled their call buzzer. One particular occasion they recalled was when someone had fallen in the bathroom and cut their head. They called an ambulance and the paramedics insisted that one of the staff accompany the person to hospital. They had attempted to call the on-call managers, without success, but had finally managed to contact a senior care worker who was able to attend so that someone could go with the person to hospital.

The shortage of day staff when the cook was absent, together with the concerns around two night staff not being enough, meant there was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the personnel files of three recently recruited staff to check whether the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. There was evidence of a Disclosure and Barring Service (DBS) check (the DBS checks for any convictions or cautions). There were documents proving the job applicant's identity, and two references had been obtained. However, in one case the applicant had named their own mother-in-law as a referee, and a reference had been obtained from them. It would be better to obtain a reference from a former employer or place of education. We also found that the application form did not include a request to account for any gaps in the applicant's career history. These details are important to verify that the applicant does not have a criminal record or anything untoward in their history.

Accidents (such as falls) and incidents were recorded, and the accident forms kept in care records. There was no analysis of trends or patterns with a view to reducing the likelihood of recurrence. We saw risk assessments on care plans which identified risks and gave limited information as to how those risks were to be addressed. We recommend that accidents and incidents should be analysed and lessons learned from them.

We looked around the home to see how clean it was and whether hygienic practices were followed. Non-slip cleanable flooring had replaced carpets in most areas of the home, but there were still some bedrooms with carpets. We noticed the odour of urine in some bedrooms. There were two cleaning staff at work during our inspection. When we arrived there were dirty clothes on the floor of the corridor outside the kitchen. The lid was not on the kitchen bin and staff were not wearing aprons in the kitchen (in the absence of the cook). Later on staff were wearing aprons to make the lunch. There was a cupboard with a plentiful supply of personal protective equipment (e.g. aprons and plastic gloves). At 9am there was food debris on the floor in the dining room. Dried food was visible on one of the tables after lunch. It had not been cleaned when we checked at 4pm.

We had seen the report of a visit by the Community Infection Control Team in April which had made a number of recommendations. The registered manager told us there were two infection control leads within the home who were implementing those recommendations. There had been an outbreak of a sickness bug

in October 2016 which had affected 11 people living in the home and eight staff. A Specialist Health Protection Nurse had told us they did not have concerns about the way the outbreak was managed, but there had been some confusion when the home was reporting figures.

We checked the records relating to maintenance of the building and equipment. It was brought to our attention that the gate at the rear of the garden needed to be made more secure.

We noted some parts of the building were cold and were told there had been problems with the heating in some parts of the building. One relative told us, "It's very cold in their room, the heating is not adjusting, they have tried to fix it but it's still the same." We spoke with one person in their bedroom who said, "Yes I'm cold, it's my legs." On one corridor the hot water was very slow to reach the taps. One member of staff told us that many tradesmen had come out to try and fix the heating system and one had reported that a wholesale replacement of the heating system was needed. On the day of our visit the radiators were working but the building was not as warm as we would have expected. The registered manager explained to us that faulty thermostats had been responsible and were being replaced, and that pipework in the loft was being repaired which should solve the heating issues.

There was evidence that the lifts were regularly serviced and repaired when necessary. The hoists and the specialist bath were also routinely serviced. There were regular visits from a pest monitoring service. The service had received a legionella inspection in March 2016 and was arranging a full legionella risk assessment.

We saw that there was a 'Viewpark fire file' kept in the senior care workers' office just by the entrance. There was a fire risk assessment dated 25 May 2016 produced by a commercial company. The file recorded that the emergency lighting, fire extinguishers and the fire alarm system were checked weekly. We saw invoices showing that the equipment was regularly inspected and serviced. There was evidence of fire drills. This meant that steps were taken to protect the building and its occupants from the risk of fire.

We were assured staff knew where the Viewpark fire file was and would be able to find it quickly in the event of an emergency. Halfway through the ringbinder there was a document entitled "Service users' dependency for fire prevention management", which listed the people living in the home and their mobility issues. We noticed that the document referred to one person as "In hospital at present", but we learnt this person had in fact passed away. Although this particular detail would not have affected an evacuation, it was evidence that the document required to be updated. The registered manager assured us that it would be updated immediately after our inspection.

Further on in the file were individual PEEPS (Personal Emergency Evacuation Plans) which gave more details about each person and their need for assistance in the event of evacuation. It was important to allow firefighters immediate access to the information they needed, and we suggested that the document with the list of people and summarising their mobility needs should be placed more prominently at the front of the file, and the file itself be readily available.

Requires Improvement

Is the service effective?

Our findings

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. We checked whether the service was working within the principles of the MCA.

Conversations we overheard led us to conclude that the staff culture was to ask consent before providing care. Examples included staff asking, "Are you cold? Would you like your blanket tucking in?", "Would you like me to cut your bacon?", and "It's lunchtime, would you like me to help you up?" These were good examples of informally seeking consent before providing care.

Viewpark Care Home Limited was using mental capacity assessments. This was an improvement recommended at our last inspection. We noted however that a standard answer was typed into each assessment. Where the form asked the question "Decision requiring test of mental capacity?", the answer given was "To decide whether the resident has capacity to make their own decisions." This answer demonstrated the correct procedure was not being followed under the MCA. Each assessment should be decision-specific. In other words a separate assessment should be made for each individual decision. This is because a person may lack capacity for some decisions but not others.

The MCA Code of Practice gives advice about how to reach a best interests decision on behalf of someone who lacks capacity to make the decision themselves. Depending on the situation, it does not have to be too formal. We saw some examples of best interests decisions recorded on care records where the correct procedure had been followed. For example there was a best interests decision in relation to one person's financial affairs. However, we saw bedrails on someone's bed but there was no associated best interests decision. The registered manager told us that the bedrails were in fact not being used, but were just there on the bed. They were removed during our inspection.

We were told that nobody was currently receiving medicines covertly, which means disguised in food or drink without the person realising. However, on two people's records we saw letters from a local GP giving permission for medicines to be given covertly. One said, "I hereby authorise you to administer medications covertly in the best interests of the patient." This is not the correct procedure in line with the MCA. Giving medicines covertly should be the last resort and a meeting should be held to determine if it is in the person's best interests. There was no evidence on the file that such a meeting had been held. This meeting should involve the care home and usually a relative as well as the GP and pharmacist, before such a decision can be reached, and the decision should be regularly reviewed. Although the GP had sent the letter, the registered manager ought to be aware of the MCA and the NICE guideline regarding covert medication. We took account of the fact that no-one was currently receiving their medicines covertly, and advised the registered manager to ensure if this arose that the correct procedures were followed.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had notified us of a DoLS authorisation in December 2015, but none since then. She did notify us, correctly, that an application had been withdrawn in October 2016 because the person concerned was no longer refusing care intervention and therefore was no longer subject to a deprivation of liberty during personal care. At this inspection we were told there were no current DoLS applications in progress.

We discussed with the registered manager the relevance of DoLS in care homes. She was aware of the need to make applications for DoLS authorisations, where the person lacked capacity to consent to a restriction on their liberty. This included whenever a person stated or demonstrated by their actions that they wanted to leave the home, but was prevented from doing so. We knew of one example within the last few months where a person had left the building unobserved. We asked whether a DoLS application had now been made for this person, but it had not. This meant that the home was not complying with the MCA. The failure to apply for a DoLS authorisation when needed was a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered manager told us that she would submit a DoLS application immediately after the inspection.

We asked people about the food and received a variety of responses. One person said, "I like the little stews [the cook] does. The food is like mother used to make." But a relative said, "It's a different cook all the time, sometimes it's the staff that cook. If it's not perfectly cooked she will refuse to eat it."

A relative told us, "Mum asks us to bring fruit, she likes fruit and they never seem to have any. She always asks me to get her a cup of tea when I come, I think the rules are she can only have one with meals. We were told we can't bring our own hot food for Mum because of health and safety." This was evidence of unnecessary restrictions on when and what people could eat and drink.

In the absence of a cook the lunch was a cooked full English breakfast. When presented with a plate of egg, bacon, tomatoes and mushroom one person said, "I don't want this". A care worker sat with them and patiently went through a long list of alternatives, including breakfast cereal, from which they chose "Bacon on brown toast." This was a good example of assisting someone to obtain the food they wanted.

A list of people who had specific dietary requirements (such as diabetes) was attached to a fridge door inside the kitchen. However, the registered manager was initially unable to identify where the list was. As the regular cook was not present we were unable to discuss with them how special dietary needs were met. We were informed a new cook had been appointed who was due to start in December 2016.

The registered manager told us they used butter to enrich foods such as potatoes. There were no food diaries kept for people needing nutritional support. We saw no evidence that soft diets were catered for. We were told that meatballs from tins were used for soft diets, but these would not be recommended. We saw a four weekly menu but did not see evidence this was in use. We acknowledged that the absence of a cook on some days each week was temporary.

We saw records showing that people were weighed monthly. Previously nutritional support had been provided by a local project named TAMSIN. That project had ceased in August 2016 and eight staff including the registered manager had received training on Malnutrition Universal Screening Tool (MUST) on 16 August 2016. MUST is a screening tool to identify adults who are malnourished, at risk of malnutrition, or obese. However, no MUST scores had been calculated for the past three months. This meant that potential risks

due to weight loss or other relevant factors had not been assessed. This was a breach of Regulation 12(1) and 12(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to access healthcare outside the home. We met a district nurse who told us that they or their team were daily visitors to the home. We saw evidence that people had regular appointments with dentists, opticians, podiatrists, speech and language therapists and other medical professionals. On one care record we saw an oral health assessment.

We looked at whether the staff received the training they needed to carry out their roles. We obtained the staff training record. There was a mix of face to face classroom training and online training. We found a high uptake of training in health and safety, food and hygiene, dementia care, moving and handling, fire training, infection control, documentation and confidentiality. Most staff had done training in challenging behaviour, and medication training, and we were assured all the staff who administered medication had done it. A lower number of staff had done safeguarding training, first aid, Deprivation of Liberty Safeguards (DoLS) and mental health (which were combined as one topic), end of life, continence training and pressure relief training. These were all topics which all care staff ought to have undertaken. We noticed that the 'Bronze silver gold' award assessor from Manchester City Council had advised following their visit in August 2016 that night staff should receive training in continence management, but this had not yet happened.

Staff confirmed that they had done the training on the record, except for one person who stated they had not done safeguarding training although they were recorded as having done it in February 2015. We saw that training was ongoing; staff were booked in to attend more training on dementia awareness during the week following our inspection.

We noted that the training policy stated that all staff without a health and social care qualification would undertake the Care Certificate. The Care Certificate is a nationally recognised qualification for staff new to working in care. We saw no evidence that any staff were enrolled on this. However, the registered manager stated that all staff currently employed had a minimum of NVQ level 2 so were not required to take the Care Certificate. We reminded her of the need to ensure that new staff without a previous qualification would embark on the Care Certificate.

Supervisions were carried out by the deputy manager. We were told that supervisions were planned every two months although the record indicated they had mainly been every three months for most people during 2016. One member of staff told us they had not had a discussion but simply been given a piece of paper. Supervision ought to be an opportunity for the member of staff to raise issues relating to their work and discuss them.
The registered manager was responsible for conducting annual appraisals but told us she had fallen behind. Many of them were due and she was planning to arrange them.

There were some adaptations to the environment to make the home suitable for people living with dementia. There were large clear signs for bathrooms and toilets. Different areas of the home were colour coded. This was partly for the benefit of fire zoning but also enabled people to recognise where their bedrooms were. People's names and a small photograph with a room number were pinned on some people's bedroom doors. We noticed that several of these room numbers did not match the numbers of the actual room, and were told this was due to people having moved rooms, but their photograph had not been updated. There was a small cabinet in the lounge with mementoes from the mid 20th century, such as a newspaper with the Queen's coronation. There were no individual memory boxes outside people's bedrooms. Therefore some measures had been taken to accommodate the needs of people living with dementia, but these were very limited.

We recommend that the provider should research and apply the latest guidance on providing a suitable environment for people living with dementia.

Requires Improvement

Is the service caring?

Our findings

People living in the home and their relatives all made positive comments concerning their care and how staff supported them. One person said, "They [the staff] are all very good, you want for nothing." Other comments we received were, "Lovely meals, clean beds, we are well looked after," and, "They treat me like I'm their grandmother." Relatives said, "Mum loves the carers here," and "She loves it here, she adores the staff." Our own observations were that the staff displayed genuine care and affection for the people living in the home, despite at times being overstretched.

The conversations we observed between staff and people in the lounge were friendly but mainly restricted to care needs. Staff ensured people were comfortable and had drinks, but did not appear to have the time to stop for long to chat with people. We saw one kind interaction when a member of staff in the lounge said, "Are you cold? Would you like your blanket tucking in?" We saw that when one person nearly tipped their chair as they were getting up staff were quick to respond and ensure they were safe.

We saw a number of examples where the respect shown to people living in the home was lacking. The dining room was made less pleasant by the dishevelled tablecloths, the dirty tables and the unclean floors. One person at breakfast had spilt their drink on the dining table. They said, "I have made a mess here", and asked for help to clean it up. We observed one member of staff looking at the spillage on the table but not responding. Another member of staff said, "I will get you a wipe in a minute" but then went with someone else to the lounge. We acknowledged that staff were over-stretched that morning due to the absence of a cook, but even so they were failing to recognise the distress that the spillage was causing to this person.

Another person had been given toast and marmalade. They could not eat this as they had no teeth. Staff then provided a Weetabix. The person was not given a clothes protector to wear. Then at lunchtime the person received the full English breakfast. They told us, "There's nothing wrong with the food but I can't chew it." They told us they had just had dental treatment and were awaiting further treatment. This had either not been communicated to the cooks or they had not considered the need to provide an alternative. A staff member spoke through the serving hatch into the kitchen saying "[name] doesn't want this." The reply from the kitchen was "We'll just give her a milkshake." This did not address the need to find a suitable alternative.

After breakfast we were talking with someone in the lounge who had cereal on their chin. This was undignified and showed that care had not been given to their appearance. Most people were well dressed in clothes appropriate to the temperature and were well groomed .

We noticed that some of the language used and the way in which people were referred to was disrespectful. For example on a toilet door in the downstairs corridor was a notice saying, "Not for use of residents." The style and content of the notice were hostile, as simply a notice saying "Staff toilet" would have sufficed. The toilet was in any event locked, so people living in the home could not access it. We also saw a poster fixed to the wall in the entrance to the home which referred to the people in the home as "patients". While there was a meaningful intent to the poster, namely to raise awareness of dementia, it could be construed as

disrespectful. There was also inappropriate language in some of the care records. On one care plan a person was described in these terms: "I am aggressive when encouraged to use the toilet." This showed lack of respect and understanding of the behavioural changes that can be the result of living with dementia.

People were not given a great deal of independence or choice as to where they sat. The chairs in the lounge were arranged around the outside of the room and not in small groups where there might have been an opportunity to be involved in conversation. We asked why this was, and the registered manager told us that they had tried to rearrange the chairs but people had pushed them back to the edges of the room. There was little interaction between people in the lounge, but we observed that when sat at tables in the dining rooms some people did talk to each other.

There was a trolley that had previously been used for distributing sweets. Staff told us that it had not been used for a long time, "Because people have dementia." This showed that one way for people to exercise choice and independence had been removed, even though many people might have been able to enjoy choosing from the trolley.

We also observed that six Zimmer frames were pushed to one side in a corner of the lounge, out of reach of the people sitting in their arm chairs. This meant that they were prevented from walking independently, and had to rely on staff to bring them their Zimmer frames if they wanted to move. Staff were not always available in the lounge. No thought had been given to rearranging the furniture so that people could sit with their Zimmer frames adjacent to them. This showed that the service was not supporting people's independence and was not having due regard to their disabilities.

We asked whether Viewpark made any provision for people who were not heterosexual. The registered manager said, "You don't like asking – these would go mad." This suggested that no thought had been given to accommodating the needs associated with people's sexuality.

We considered that the examples of disrespect, and failure to support people's independence, were a breach of Regulation 10(1) and 10(2)(b) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw an improvement in terms of confidentiality since the last inspection in that care files were locked in a cabinet when not in use, and the information in the PEEPS was no longer on public view. Several staff raised concerns with us regarding a general lack of confidentiality within the home but we found no evidence of this directly affecting people living in the home.

We saw in one person's care records that an advocate had been involved in supporting them prior to their arrival in Viewpark Care Home Limited. We did not see any evidence, however, of ongoing involvement of advocates for people who lacked capacity and did not have family members who could represent them.

Inadequate

Is the service responsive?

Our findings

We asked visitors if they knew about their relatives' care plans and whether they had been consulted about their contents. One visitor said, "I know there is a care plan but I just leave it to them." Another visitor said, "We have never discussed a care plan so I don't know if mum's food issues are in it."

Care records included a document called "All about me". This was intended to be a detailed document describing the person's history, their family, their likes and dislikes, and interests and hobbies. Such information is helpful in enabling staff to deliver person-centred care, because they have knowledge of the person and can engage them in conversation about their interests. On two of the records we looked at, the "All about me" document was blank. On one was a sticker saying, "No background given." Three other files did have some information in the "All about me" section but it was limited.

The care plans themselves were not sufficiently detailed. They stated people's needs but did not give sufficient instruction or guidance as to how those needs should be met. This was vital information especially for new staff or agency staff who would not have prior knowledge of people's needs. For example on one care plan we saw under the heading 'Medication' there was a blank area with a circle in the middle, which gave no information. Under diet it recorded that the person "Will eat all the wrong diet if given. Kitchen and care staff are all aware." The care plan gave no indication of what the correct diet was.

Care plans were reviewed and updated but this was not on a regular basis. One care plan had last been updated in January 2016, and two others in May 2016. This meant that there was no evidence that people's needs were being regularly re-assessed and changes made to care plans when needed. There was a form on one care plan for staff to sign to show that they had read the care plan; it was blank.

We asked to see the care records of one person who had been living in the home for a short time. We were provided with two A4 sheets of paper, which carried very basic information about this person, and a set of daily notes from the date of admission. One piece of information was that they had two grade 3 pressure ulcers on their sacrum (the lower part of their back). There was no corresponding information on how these pressure ulcers required to be treated. On the daily notes it stated four hourly pressure relief, but that the person would turn on their back again. There was no record of a referral to Tissue Viability Nurses (TVNs) or the district nurses. The daily records for this person recorded their dressings had come off but did not detail how these had been replaced or by whom. We also found the provider was not doing everything reasonably practicable to reduce the risks associated with pressure area care. This was a breach of Regulation 12(1) and 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This person had received a visit from the dentist the previous day where their dentures had been removed and taken away but there was no record of this in the daily notes. The registered manager told us that this was because it had been late in the day, but care notes are supposed to be a contemporaneous record. One member of staff told us they had no information about this person at breakfast the next morning. The lack of recording was a breach of Regulation 17(1) and 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were concerned that the care plan did not meet this person's needs and asked the registered manager to submit a revised care plan to the CQC. When this arrived two days after our visit it contained exactly the same information as had been on the A4 sheets of paper. There was also a new document entitled 'risk assessment' which did state that district nurses were now visiting twice weekly to re-dress the pressure ulcers. There was also now a reference to the dentist's visit. The care plan and risk assessment taken together did represent a fuller statement of the person's needs and how to address them than we had seen on the day of inspection. They still did not represent an adequate care plan which would enable staff to deliver individualised care that met this person's needs. There was for example no information about the correct pressure for the air mattress. We were concerned that the information in the risk assessment document had not been available earlier and was only produced at our request.

We also found other people with pressure relieving mattresses where there was no record of the correct setting for the person's weight. This meant the provider could not demonstrate people were being supported appropriately in relation to the risks associated with their skin integrity.

The poor care plans, lack of reviews, and the failure to write a meaningful care plan and assessment of needs for someone who had been in the home for a short time constituted a breach of Regulation 9(3)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Viewpark Care Home Limited did not have an activities organiser. We were told that there had been one earlier in the year, and that they had devised a number of appropriate activities such as memory games, skittles and I Spy. The assessor from Manchester City Council reported in August 2016 that "Residents were alert, animated and engaged during the activity session." Unfortunately the activities organiser had left the home on 2 September 2016 and not been replaced. One member of staff told us about a volunteer who was coming in one day a week. The registered manager did state that Viewpark Care Home Limited was trying to recruit a new activities organiser. This meant that for the time being staff were expected to provide activities but they told us they did not have enough time to do so. During the morning of our visit "Armchair exercises" was written on a whiteboard in the hall to indicate that afternoon's activity. During the afternoon we did not see any armchair exercises taking place.

One of the questions in the 'life history' section of the All About Me document in the care record was "What were my hobbies?" Whereas some hobbies might be ones which could be continued. We were told that one person had enjoyed knitting, and some equipment had been provided, but that they had now stopped knitting. We did see one person enjoying colouring in a book. They told us that a member of staff had provided the book. The member of staff confirmed that they bought colouring books and did not get reimbursed by the management. This demonstrated a thoughtful and generous approach by the particular member of staff.

We saw no evidence of staff using techniques or equipment, such as photo books or word charts, to assist in communicating with people who had limited communication ability. There were two dolls in the lounge, although they were not being held and not being offered to people. Dolls can be used with great therapeutic benefits by some people living with dementia. We were informed that one person had a doll named "Jennifer". A member of staff told us, "We can't find Jennifer; we have looked all over. We tried to give her a different doll but she just said 'That's not Jennifer' and wouldn't take her." This demonstrated the bonds of affection that can develop for dolls used in this way and the importance of staff ensuring people have access to their preferred doll.

We learnt that some people had gone to a local school the previous Christmas to watch a play. No trips had taken place recently. We asked one person whether they had been out of the home. They replied, "I haven't.

I don't feel like I can go out. I'm not confident." When we asked people in the two lounges what they did with their time during the day, replies included "I just sit here", "Nothing", and "I like colouring my book." Staff told us that there were entertainers who came in once a month.

We found that insufficient activities were taking place to meet the needs of people for recreation, physical activity and mental stimulation. This was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The complaints policy stated it was the home's policy to welcome concerns being raised and to regard them as an opportunity to improve standards. Nobody living in the home and no visitors could give examples of raising concerns or complaints. The registered manager had told us in the PIR that the service had received no formal complaints within the past year, and there were none recorded at the date of inspection. However, we were made aware of one verbal complaint that had been made, but it had been treated as a concern and not recorded. This meant that not all concerns were being captured, and consequently lessons were not being learned from them.

Inadequate

Is the service well-led?

Our findings

It is a requirement of the regulations that providers display the rating received in their last inspection conspicuously within the home and also on their website. The home was not displaying the rating of "Requires improvement" from the last inspection in June 2015. The registered manager told us she was not aware of the requirement to display it in the home. She stated that Viewpark Care Home Limited did not have its own website. Failure to display the rating in the home was a breach of Regulation 20A(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The aims and objectives of the service were set out in the 'service user guide' which was given to everyone when they moved in and/or their relatives. There was a copy on the table in the hallway. The guide set out the values of the home, which were privacy, dignity, independence, choice, rights and fulfilment. These were good values for the home to aspire to, but our inspection found these were not always embedded in practice.

There was a set of policies and procedures which had been produced by a commercial company. The file was kept in the registered manager's office and there was no record of staff accessing the file to read policies. During the inspection the registered manager asked if they could reduce the number of supervision meetings they held with staff as these were currently planned for every six weeks. They were not aware that their policy stated they should be completing these meetings every three months. This showed us the registered manager was not familiar with or consulting the policies to guide their approach to the management of the service.

We asked what regular audits were carried out to monitor the quality of the service. There was a medication audit, conducted by the registered manager. This had been done each month in the first few months of 2016 but more recently had been done every two months. The most recent audit was dated 29 September 2016. The audit took the form of an audit tool with typed questions. The questions were appropriate and if answered thoroughly would represent a meaningful audit of the medication systems and processes within the home. We saw that the questions had been answered by hand in December 2015 and January 2016, but that since then typewritten answers were recorded. The answers were virtually identical from one month to the next, even including the same spelling mistakes. This strongly indicated that the document including answers had been duplicated, and it reduced the value of the audit because no reliance could be placed on the auditor genuinely having examined and answered all the questions. Further evidence of this was the number and range of issues and errors that we had found during this inspection, which had not been identified in any of the audits.

We also looked at care plan audits. These had taken place every month in 2016 except August. In each audit the registered manager looked at the care files of three people and recorded the initials of the people whose files she had looked at. Some people's files had been looked at more than once, others not at all. We saw that on one occasion the registered manager had noted a need for improvement, recording "Care plan found untidy. Paperwork in other file," and had written in the action column "Staff advised and checked and put correctly." This showed that the audit could be used to generate improvement. However, there was no

audit tool or list of questions, which meant that there was no record of what had been checked. In our last report we commented, "This was not an effective audit as there was no checklist of questions or areas looked at." Nothing had changed, which meant that the audit was still lacking in depth. Some of the issues that we had noted, such as the blank "All about me" sections, and the lack of information about how to meet identified needs, had not been picked up by the audits. Nor was there any reference in the audits to those care records where monthly reviews had not been done for many months.

In our last report we had found that the lack of effective systems for auditing of care files and medication was a breach of the relevant regulation. We found that this remained the case, and that the efficacy of the medication audit had reduced. This was a breach of Regulation 17(1) and 17(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that the managers did occasional spot checks at night. We saw there had been infection control audits, and a walkround audit of the building. We noted that this audit had apparently not identified damaged walls in one bedrooms, broken furniture and the need to improve the signage around the home. In relation to the broken furniture the registered manager explained that it belonged to the person and their family were reluctant for it to be moved. Nevertheless if it was a hazard then it would be the home's responsibility to remove it.

The service invited feedback by means of a form which was available on the table by the entrance next to the signing in book. The survey asked for responses to a variety of questions about the quality of the service. We requested to see completed survey forms but these were not made available during the inspection. We also understood there was a weekly meeting for people living in the home. This asked people's views about the care in the home, the food, and about activities. Although we made a request for minutes of such meetings we were not shown any. However, we saw evidence that they had taken place at least up to August 2016.

The majority of staff who spoke with us expressed concerns about the support provided by management. They did not feel that their concerns were listened to. They considered that the two managers did not often lend a hand when they were short staffed, for example during the recent sickness outbreak which had affected eight of the staff in turn. They expressed concerns that when they had asked for help on the floor from the management team it had not been forthcoming.

We discussed this with the registered manager who contradicted this account, and said she had come in from leave in order to help on the floor on that occasion. Several staff also told us that the two managers would often leave the building together to go shopping, and on one occasion took their holidays at the same time which created difficulties for the senior care staff who were left in charge. They said there was never a manager present at weekends except when one of the owners visited. Although one of the two managers was supposed to be on call at night and at weekends, staff said it was difficult or impossible to contact them and they often called one of the senior care staff instead. In summary staff felt that the management were not supportive.

Staff also raised with us a number of issues relating to their shifts, and their terms and conditions. Although these issues had no direct bearing on the welfare and safety of people living in the home, we were concerned that any further decline in staff morale might begin to have an impact.

We asked to see minutes of staff meetings. We were shown minutes of a meeting held on 2 June 2016. The minutes recorded that policies and procedures had been discussed, with a warning that if they were not followed there would be "disciplinaries". The remainder of the minutes recorded the information given out

to staff. There was no indication that staff had been given or taken the opportunity to raise issues of their own. There was however a reminder that if staff had concerns they could go to the senior staff or the office. The minutes finished on a positive note of encouragement: "Keep the great work up with all our residents and relatives."

There were separate minutes of meetings with night staff, which did record discussions of their specific concerns. However, several staff told us that the minutes did not accurately reflect what had been discussed at the meetings.

A relative informed us, "Mum had to go to the hospital last Monday, they said we would be charged £8 an hour if we couldn't take her." The home charged people for the entertainers who came in to perform about once a month. We had heard of instances where people had been charged who had not been present for the entertainment because they stayed in their bedroom. The registered manager told us this had been a, "Genuine mistake." Although the registered manager told us people were aware of the charge for entertainers we spoke with a relative who was not aware their family member made a direct contribution which we found was up to £10 per visit. People should have been made aware in advance of any costs associated with in-house entertainment in order to consent to making a contribution to the costs.

The registered manager knew about her responsibilities under legislation to notify the CQC about defined events within the home. At our last inspection we reported that the registered manager had not submitted notifications about abuse and serious injuries. Prior to this inspection we had received such notifications, which meant that the registered manager had responded to the previous report. We did not discover any events that ought to have been reported, with one possible exception. This was the allegation of neglect which had not been reported to the local authority, mentioned earlier in this report.