Park View Nursing Home Limited

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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?	Inadequate
Is the service caring?	Inadequate
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 13 and 22 April 2015 and was unannounced. At the last inspection on 26 November 2014 we found six breaches in regulations which related to medicines, records, recruitment, staff training, safeguarding and quality assurance. We took enforcement action and issued warning notices for the breaches relating to medicines and quality assurance which included timescales for compliance of 26 January 2015 and 26 February 2015 respectively. The provider sent us an action plan for the other breaches which told us improvements would be made by 31 March 2015. At this inspection we found improvements had been made in relation to recruitment, however we found breaches of other regulations.

Park View Nursing Home provides accommodation and nursing care for up to 43 older people. There were 32 people living at the home when we visited on the second day. This included 12 people receiving nursing care, 14 people receiving personal care and eight people receiving

Summary of findings

intermediate care. Intermediate care aims to rehabilitate people to allow them to return home following a hospital admission or to prevent the need for long term residential care.

Accommodation is provided over two floors with lift access between the floors. There are communal lounges and a dining room as well as toilets and bathroom facilities. A kitchen and laundry are located on the ground floor.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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.

Although people told us they felt safe we found people's safety was compromised. People were not kept safe from harm as staff had not received up to date training in safeguarding and allegations of abuse were not always recognised or reported. Poor infection control practices meant that people were not protected from the spread of infection. Systems in place to check and respond to environmental risks were not effective which meant health and safety and fire safety issues were not always addressed.

Some improvements had been made in how medicines were managed, although recording systems were inconsistent which meant we could not be assured people were always receiving their medicines as prescribed. We found people had access to health care services, although we were not assured these were always accessed in a timely way.

We found improvements had been made in recruitment processes with checks being completed before staff started work, to make sure they were safe and suitable to work in the care sector. However, some staff training was not up-to-date which put people at risk of unsafe or inappropriate care and we found there were not always enough staff on duty to meet people's needs.

Staff had not received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and lacked understanding of this legislation.

People told us they enjoyed the food, although we found mealtimes were poorly organised which meant some people had a long wait before they received their meals. There was a lack of meaningful activities for people, although people told us they enjoyed the outside entertainers who visited.

People spoke positively about the staff who they felt were kind and caring. Yet we saw practices that showed a lack of respect for people and compromised their dignity. People's care was not always planned or delivered in a way that met their individual needs and preferences.

We found the home was disorganised and chaotic with poor communication systems which meant senior staff were not always aware of what was happening in the home. There was a lack of quality assurance systems and those that were in place were ineffective and did not support the management of the home in identifying where improvements were needed.

Overall, although we found improvements had been made with regard to recruitment, there were significant shortfalls in the care and service provided to people and the home's internal quality assurance systems had failed to pick these up. Following the inspection we contacted the fire authority, the infection prevention and control team and the local authority safeguarding team to share our concerns about the service.

We identified seven breaches in regulations and the Care Quality Commission is considering the appropriate regulatory response to resolve the problems we found.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements

Summary of findings

have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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. Although people told us they felt safe we found staff had not been trained in safeguarding and abuse was not always recognised and acted upon appropriately.

Although some improvements had been made in medicines management, poor recording systems meant we could not be sure people always received their medicines as prescribed.

Environmental risks were not identified or managed promptly which put people at risk of harm. Poor infection control practices meant people were not protected from the spread of infection.

There were not always sufficient staff on duty to meet people's needs.

Is the service effective?

Inadequate

The service was not effective. People told us staff knew their needs well, however, we found staff training was not up to date.

Staff had not received training in, and lacked understanding of, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Although people said they enjoyed the food, organisation was poor which meant delays for some people in receiving their meals.

Access to health care services were in place but were not always sought in a timely way.

Is the service caring?

Inadequate

The service was not caring. Although people praised the staff and we saw some staff interactions were warm and friendly, we also observed practices which showed a lack of respect for people and undermined their privacy and dignity

Is the service responsive?

Inadequate

The service was not responsive. Care planning was incomplete, not up to date and did not provide staff with the information they required to meet people's needs.

People enjoyed the entertainment provided by performers coming into the home, however, aside from this there were few planned activities for people.

People knew how to make a complaint and told us they would feel able to do so.

Is the service well-led?

Inadequate

The service was not well led. People were not protected because the provider did not have effective systems in place to monitor and assess the quality of the services provided.

The home lacked consistent leadership and communication systems were poor. Managers and nurses were not adequately informed and aware of what was happening in the home.

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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.

This inspection took place on 13 & 22 April 2015 and was unannounced. On the first day two inspectors and a pharmacist inspector visited the home. On the second day there were two inspectors, an inspection manager, a pharmacist inspector and an expert by experience with expertise in dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority contracts and safeguarding teams.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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 did not send a PIR to the provider before this inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time observing care in the lounge and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We spoke with 13 people who were living in the home, three relatives, five care staff, three nurses, a physiotherapist, the cook, two maintenance staff, the deputy manager, the registered manager and the provider.

We looked at eight people's care records in detail and others to follow up on specific information, five staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

At the previous inspection in November 2014 we found a regulatory breach in relation to safeguarding as the provider had failed to prevent neglect in relation to five people who had not received their medicines because stocks had run out. Although we found at this inspection some improvements had been made in respect of medicines, we identified other safeguarding concerns.

At this inspection people we spoke with told us they felt safe in the home however, we found people's safety was at risk as staff had not received up to date safeguarding training and safeguarding incidents were not always identified and acted upon.

One person said, "I know I'm safe – I can't fault it here." A visitor told us, "My family member was in another place before this and it was awful, she had a lot of bruises. Here is so much better. She never says there are any problems." However, one person raised concerns with us about their safety and said they had tried to raise these issues themselves but said, "…the staff and bosses don't do anything about it." We saw evidence in this person's records which showed concerns had been raised on five occasions in the last two months yet when we spoke with the registered manager they confirmed these allegations had not been referred to safeguarding. This meant the provider had not taken action to address the person's concerns and prevent any reoccurrence of the cause of these.

The deputy manager told us 14 staff had received safeguarding training since the last inspection in November 2014. However, the training had not been fully completed for any of these staff. The deputy manager confirmed nine staff had watched a safeguarding DVD yet they had not completed the workbook which tested their knowledge and learning. Five staff had completed the workbook and watched the DVD, yet the workbooks had not been reviewed or marked to ensure people had understood the training they had been given. The deputy manager said they had wanted staff to complete the safeguarding training provided by the Local Authority but had been told by the registered manager there were no places currently. The deputy manager said they were going to look at booking staff on future safeguarding courses with the Local Authority but this had still to be arranged.

The deputy manager and provider told us there had been two safeguarding incidents since the last inspection, both of which had been referred to the Local Authority safeguarding team. We saw records to confirm this. However, neither incident had been notified to the Commission as legally required. When we asked the deputy manager about this they said they were not aware they had to notify us. We saw investigations had been undertaken into both incidents and disciplinary action had been taken against a staff member who was dismissed. Yet no referral had been made to the Disclosure and Barring Service (DBS). This meant the provider had not taken action to inform the relevant authority of their concerns regarding the dismissed staff member, in order for the risk of the person working with vulnerable adults in the future to be reduced.

We asked the provider where the sharps boxes were being kept as at the last inspection they had been stored openly in the dining room where people could access them. Sharps boxes contain used syringes and other potential contaminated objects. The provider told us the sharps box was now stored in an unlocked cupboard in the dining room. This meant they were still accessible to people using the service and could pose a potential hazard.

Over the two days of our inspection we identified incidents of abuse which had not been identified by staff or reported to safeguarding. These related to neglect and acts of omissions in care provision as well as allegations made by one person against staff. We referred these incidents to the Local Authority safeguarding team. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the previous inspection in November 2014, we found that medicines were not handled, recorded or administered safely. This was a breach of regulations and placed people who used the service at risk of harm. We issued a warning notice to the provider requiring swift action to be taken to ensure that the service became compliant with the regulations. At this inspection we found whilst significant improvements had been made, appropriate arrangements for the safe handling of some medicines were still not in place.

Inadequate

Is the service safe?

We found people were not always fully protected against the risks associated with the unsafe use and management of medicines. We looked at medication stocks and records for five people staying in the intermediate care unit and eighteen people who were living in the home.

Most medicines were stored safely in locked cupboards and trolleys. We did however see a small number of medicines left out on a table in the dining area as well as an unlocked cupboard in the dining room that contained some discarded medicines. Medicines must be kept securely at all times in order to protect people living in the home against the risks associated with the unsafe storage of medication.

Most medicines could be accounted for clearly and showed that the majority of medicines had been administered correctly. However, a check of stocks and records for ten people showed that occasionally medicines had been signed for, but had not been given, or given, but not signed for. There were missing signatures on records and it was unclear if medicines had been given or omitted at those times. Where medicines were prescribed at a variable dose, the actual dose administered had not always been recorded. The service had introduced a new system for recording discrepancies, such as missing signatures, but this was not used consistently and there was no record of any action taken to address the issues highlighted. Records for the application and use of creams and other external preparations were incomplete and unclear meaning that we were unable to tell whether or not these products had been used as prescribed.

Arrangements had been made to ensure that people needing their medicines at times other than the 'medicines rounds' were given them correctly. However, we saw that people were not always given their medication at the correct time with regard to food and drink. We saw that medicines which needed to be given half an hour before food were given with medicines which should be given with or after meals. Medicines must be given at the correct times to make sure they work properly.

During our visit we observed nurses preparing and administering medicines to people living in the home. We saw that people were supported to take their medicines in different ways, depending on their needs. On occasions, people did not want, or were not ready to take their medicines and we saw that nurses would return later to reoffer them. We saw one nurse consistently preparing medicines and completing records at a table where people were eating. This practice showed little or no consideration for the privacy and dignity of the people sat at the table or for the person whose medicines were being prepared. Many people were prescribed medicines that needed to be taken only when required. Whilst some of the permanent nursing staff could tell us how these medicines should be given, we found that there was not enough information available to guide agency nurses about how to give these. For example, there was no information recorded to enable staff to choose how much medicine to give when a variable dose was prescribed or how to tell when a person with communication difficulties needed their painkillers. It is important that this information is recorded to ensure people are given their medicines safely, consistently and with regard to their individual needs and preferences at all times.

We were shown a recent audit (check) that had been carried out to determine how well medicines were managed within the service. The audit was very basic and failed to address many different aspects of medicines management. With the exception of creams, medicines were only administered by registered nurses. We were told that a competency assessment had been developed that would ensure nurses had the skills and competence to carry out their duties safely, but this had not yet been put into practice. We saw that appropriate action was taken to protect people against the risks associated with medicines when prescribing, dispensing and/or administering errors were spotted. It is essential to have a robust system of audit and checks in order to highlight concerns and make any improvements necessary**.** This was a breach of Regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found personal evacuation plans (PEEPS) on how to evacuate people safely in the event of a fire had not been completed for people using the service. At this inspection we asked to see the PEEPS and the provider told us there was a traffic light system in place. This meant each bedroom door had a red, amber or green card on the door to indicate the level of assistance the person occupying that room required. We saw from the key red indicated the person needed a sledge, amber the assistance of one or two staff and green meant the person walked with an aid and needed assistance. We asked to see the written assessments because we wanted to see how these assessments had been made and to see if people

needed one or two people to assist them in an emergency, but none were in place. This meant there were not clear instructions for staff on how to evacuate people safely in an emergency. The deputy manager told us this information could be included in the new care plans in the safety and wellbeing section.

We asked the provider for the environmental audits and they asked us what we meant. We said these would be the audits of all areas of the home that would identify any improvements that were needed. The provider told us the maintenance staff did this every day and attended to any repairs that were needed. No records of these audits were made. On the second day of our visit one of the maintenance staff showed us a checklist they had devised to check the environmental standards in bedrooms at the service. However, these checks had not been implemented.

The provider gave us a list of the areas that were checked on a daily basis. We saw these checks included checking doors were closing properly and removing any equipment that was blocking corridors and stairways. When we looked around the building we saw the fire doors to five bedrooms were not closing securely into the door frames and the door to another bedroom was propped open with an oxygen cylinder. We also saw boxes, furniture and other items being stored on the corridor leading to a fire escape and the final exit door was blocked by an empty box, a box of paperwork and a file. We spoke with two of the maintenance staff who told us they had completed all of their checks that morning. This meant these checks were not effective as they had not identified the issues with the fire doors or fire escape. We reported our concerns to the fire authority who visited the home on 22 April 2015.

We looked around the building and found window restrictors on all of the bedrooms on the first floor windows except one. However, we found the restrictors could easily be removed and windows could then be fully opened. We spoke with the provider about this and they asked us what restrictors we wanted them to put on. We advised there was very specific guidance from Health and Safety Executive (HSE) that they would need to refer to as it was their responsibility to make sure people using the service were kept safe. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a notice on one of the bathroom doors which listed items not to be stored in the bathroom such as personal toiletries, catheter bags and hoist equipment. When we looked in the room we found these items were stored there. We found although some areas of the home were clean others were not. We saw toilet brushes in two of the toilets were visibly soiled and some toilets were not clean. Other equipment such as hoists and stand aids were dirty and we noticed a strong odour of urine in one bedroom.

We looked at one person's care plan and saw they had been discharged from hospital the previous day with an infection (Clostridium Difficile), which was being treated with antibiotics. This type of infection required staff to take additional infection prevention precautions. We found these were not in place. We saw the person was in their bedroom and there was nothing outside or inside the bedroom to indicate this person was being barrier nursed. We saw two staff who were in the room with the person, one of whom was a nurse, were not wearing personal protective equipment. The nurse told us the person was not being barrier nursed, however, the registered manager told us they were. We found only some of the staff were aware this person had an infection. We had observed the handover from night staff to day staff and this information had not been communicated to staff. When we asked the provider and deputy manager, they were also unaware of this person's condition. This meant people were not protected from acquiring an infection as effective infection control and prevention measures were not in place.

We asked to see the home's infection control policy. Although the policy was dated September 2010 there were clear guidelines for the management of Clostridium Difficile infection and our observations showed these were not being followed. We reported our concerns to the infection prevention and control department at the Local Authority. This was a breach of Regulation 12 (2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a food hygiene certificate dated 11 November 2014 displayed in the kitchen which gave a food hygiene rating of one. There are six ratings with five being the highest score and zero the lowest. A score of one means major improvements are required. We asked the owner about this and they told us they had completed most of the actions required and they had bought new chopping boards but these were not in use yet.

We spoke with people about staffing levels in the home. Few expressed any concerns and no one felt that a lack of

Is the service safe?

staff had impacted on their care at any point. One person said, "During the day there are always this many staff. At night there are three and a nurse, and that's plenty. There's always someone there when you need them." Another person said, "There are plenty of staff around. Plenty of people around at night."

We asked people if staff were quick to respond when call bells were used and everyone was very positive in describing their experiences. One person who spent most of their time in their room and was dependent on staff to assist them told us, "There's a reasonable response to the call bell. I know that some people might be more in need than me – if I need more water I let them know in good time. If it's an emergency I'd use the emergency button, then they would know I needed them urgently." Another person said, "I've never seen anyone having to wait for assistance. The buzzer system works quite well really – they can't ignore it if it goes off." A further person said, "If you press the buzzer they come quickly. You don't have long to wait. I can't say I've ever seen anyone waiting for help – they're pretty good, the staff."

People told us they felt that the staff team was stable and they knew the staff and we heard people refer to staff by their names. Where people referred to having seen agency staff they felt that this was an exception rather than custom and practice. One person said, "It's generally the same people staff-wise. We often have an agency nurse." Another person said, "We don't have many temporary staff."

We asked the deputy manager about staff breaks and they told us these were now split so there were always staff available. This was confirmed by one of the care staff we spoke with.

The provider and deputy manager confirmed the usually staffing levels were two nurses and seven care staff during the morning, two nurses and six care staff during the evening and one nurse and three care staff at night. The provider said this was sometimes increased to eight care staff in the morning and seven care staff in the evening. We looked at the staff duty rotas for the period covering 16 March 2015 to 26 April 2015. We found it was not always clear how many staff were on duty due to the number of amendments made to the rosters. However, we were able to determine there were times when staffing levels had fallen below the levels quoted by the provider. For example, on three out of five Sundays and one Saturday there was only one nurse on duty throughout the day from 8am until 8pm. On one of these Sundays there were only five care staff working with the nurse from 2pm until 8pm, one of who was a trainee. On the other Sunday when there was only one nurse, two of the six care staff working from 2pm until 8pm were an apprentice and a trainee. We considered these staffing levels were insufficient to meet people's needs.

One staff member we spoke with felt there were not always enough staff on shift. They said, "There's currently five on shift. Some days there are eight which is fantastic."

The provider told us they struggled to recruit qualified nurses and were using agency staff to cover some shifts. We saw from the duty rotas that the registered manager and deputy manager were regularly working over 50 hours a week. We saw on one day in April 2015 the deputy manager had worked all night and the following day. On the night shift there had only been two care staff working with the deputy manager instead of three. This is unsafe practice which puts the staff and people who use the service at risk of harm. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in November 2014 we found recruitment checks had not always been completed as legally required. At this inspection we found improvements had been made and the regulation had been met.

The provider and deputy manager told us no new staff had started work since the last inspection. Four care staff were in the process of being recruited and we looked at their recruitment files. We saw all four had completed application forms and references and criminal record checks (DBS) had been applied for. Not all of these checks had been received back. The deputy manager told us all four staff were attending induction training the following day, however the provider assured us that the staff would not start working in the home until all the recruitment checks had been obtained and were satisfactory. When we visited on the second day one of these staff was working in the home shadowing a more experienced staff member. We found full recruitment checks had been completed for this staff member.

We saw DBS checks had been obtained for the two staff who did not have up-to-date criminal record checks when we last inspected in November 2014.

Inadequate

Is the service effective?

Our findings

At the last inspection in November 2014 we identified staff had not received up-to-date training in moving and handling and safeguarding and had not had any training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) or health and safety. The action plan submitted by the provider gave dates for this training to be completed and the last date was 7 April 2015. The action plan also stated there would be an up-to-date training matrix. At this inspection we found although some training had been delivered, not all staff had received it.

At this inspection we asked people if they thought they were cared for by staff who knew what they were doing. With one exception people told us they felt the staff had adequate training to assist them with their lives. One person said, "The staff seem to know what they are doing. I've never had a problem with them."

The deputy manager told us they had started putting together staff training files and would be inputting staff training details onto a new computer system which had been installed two weeks prior to our inspection. They told us the training matrix was not up-to-date and was the same one that had been in place at the inspection in November 2014. It was difficult to establish what training had been completed as the deputy manager struggled to locate the records we asked for. A new office had been created upstairs from a store room, however this had not been cleared out properly and we saw chaotic office systems meant paperwork was piled high on desks and other surfaces.

The deputy manager told us 24 staff had completed moving and handling training in December 2014 and we saw training certificates which confirmed this. The deputy manager said another moving and handling training day had been planned for 15 April 2015 but this had now been changed to 27 May 2015, when the rest of the staff would receive the update.

The deputy manager told us none of the staff had received training in the MCA and DoLS or health and safety. Although the provider's action plan stated health and safety training would take place in March 2015, the deputy manager told us this had not occurred. They said health and safety was being covered in the induction training for new staff on 15 April 2015 and four of the existing staff would also be attending this training.

We saw a list which showed 35 staff had received fire safety training in March 2015 and the deputy manager told us the remaining staff were attending a session the following afternoon, which would mean all staff had received updated fire safety training.

The deputy manager told us 12 staff had received dementia awareness training in February 2015.

We asked about medicines training and were told nine of the night care staff had completed medicines awareness training and saw certificates to confirm this. We asked to see evidence to show what medicines training the four nurses employed in the home had received. The deputy manager and provider were unable to provide any evidence of this training. The deputy manager said they thought medicine training was being arranged by the registered manager but it had not happened yet. The deputy manager told us they had created documentation to assess staff competencies in medicines management but these had not been implemented yet.

We saw induction booklets had been prepared for the four new staff who were attending training the following day. We saw the booklets referred to the new Care Certificate and the deputy manager confirmed the induction had been planned to meet these new standards. The deputy manager said they intended to take all the existing care staff through these standards.

When we visited on the second day we met with one of the new staff members who had started working in the home. They told us it was their second shift and they were shadowing an experienced care staff member. They told us they had been unable to attend the induction day, which was confirmed by the deputy manager. The staff member said they had been given induction booklets two days ago but had not started these yet. They said they had not had any training or induction and had not been shown the fire procedures or had any moving and handling training. They said they were booked in for moving and handling training in May 2015.

We spoke with another staff member who told us they were a trainee. They had been working in the home for seven months and told us they were working through their

induction with the deputy manager. We looked at this person's training file and saw their induction record was only partially completed. This meant staff were not being given training relevant to their role and this could leave people using the service at risk of receiving unsafe care and support. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff we spoke with said they had not received training in the Mental Capacity Act 2005 (MCA) or DoLS and showed little understanding of this legislation. One nurse we spoke with mentioned a DoLS form which the registered manager had completed for one person and said, "I was unaware there was such a thing." We asked the provider, registered manager and deputy manager if anyone at the home had a DoLS authorisation in place and they said no.

We looked at the care records for one person who had been admitted from another care home in February 2015. The records showed this person had had a DoLS authorisation in place at their previous home, however there was no information to show why the DoLS had been in place. We asked the registered manager if they knew what the DoLS authorisation had been for and they told us they did not know. There was no information about the DoLS in the assessment carried out by staff from Park View and no DoLS application had been made. When we returned on the second day we saw the registered manager had made an urgent DoLS application to the local authority. We asked the registered manager and the provider if any other applications had been made and they told us they had not. We asked the registered manager if they had completed any DoLS training and they told us they had not. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they could not make drinks or access snacks themselves but said these were brought to them. One person said, "They come round with drinks and biscuits. If you ask they generally say, "The trolley will be round soon." Another person told us, "We get snacks and drinks when the trolley comes round. I suppose I could just ask for one."

People we spoke with were positive about the food. One person said, "We can choose what we have to eat." Another person told us, "We get lovely food, always a couple of choices." A further person said, "The meals are very good, the food is always nice and hot when it comes."

We observed the lunch service. There was a long delay from when people started to enter the dining room to food being served to them. We observed one person being assisted into the dining room at 11:20am and the first food was served at 12:10pm. We saw another person was brought in by staff at 11.37am and was served their meal at 12.19pm. This meant people were seated and waiting for food to be served for up to 50 minutes. Cold drinks were offered from 12:00pm. We observed the service was functional rather than a relaxed and sociable experience. Staff did not interact with people apart from when serving their meals, and although some people chatted to each other occasionally most sat and waited for their meal in silence. There was a music system in the room but this was not put on until part way through the meal.

Food was served on small side plates, which was the same way cooked breakfasts were presented. The food was well presented and we heard people say they were enjoying it.

We did not see anyone use adapted cutlery or plate guards. One person was offered a cold drink in a plastic cup and objected, saying they wanted a glass like the one their dining companion was using. The staff member looked annoyed when the person rejected the wine glass that was brought for her and the person pointed at glass tumblers on the trolley and said, "One of those." One staff member offering cold drinks repeatedly said the choice was between, "Orange and holy water," the latter referring to what some staff called lemonade and others referred to as fizzy water. This may have been disrespectful to some people's religious beliefs and confusing for people living with dementia. It was not clear whether it was lemonade or fizzy water people were drinking.

We observed staff interact with one person who had not eaten much of their main meal. The staff member offered to assist and after providing the person with one mouthful they loaded the fork with food without waiting for the person to indicate that they were ready, but then broke off from assisting without explanation or apology and without giving the person the food. The staff member returned a short while later, but although they asked, "Are we having a bit more?" they did not offer further interaction or

encouragement as they assisted the person. The staff member then again walked away to clear a plate from the table before the person had finished their meal and did not return. The person remained looking at their food until another staff member sat beside them and asked why they had not eaten their dinner. The staff member attempted to assist the person, who repeatedly pushed the fork away when it was offered. The staff member did not acknowledge this and persisted in giving the person the food until the meal was eaten.

We spoke with the kitchen assistant and cook. We saw notices in the kitchen which identified people who required special diets such as soft food, diabetic diets and any allergies. They told us meals were not routinely fortified and there were no people on fortified diets.

Care records we saw showed health care services had been accessed such as the tissue viability nurse, GPs and dieticians. However, we were not assured that health care support was always accessed in a timely way. For example, we saw one person whose toenails were very long and it had been identified they needed to see a chiropodist but this had not been arranged. Another person notes showed they had been reviewed by the dietician in August 2014 and it had been agreed the person would be reviewed again in two weeks but there was no record to show this had been done. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

People we met spoke positively about the staff and described them as 'nice' and 'lovely'. One person said, "It's a nice place to be." Another person said, "The staff are marvellous – they're always pulling my leg." A further person said, "The staff are nice and friendly." Another person told us, "The staff are nice and patient, they never leave you without anything." Another person said, "The staff are really good and helpful. I can't speak highly enough of the staff."

We saw some interactions between staff and people were warm and friendly, however we noted conversations were mainly confined to talk around tasks. We observed several instances where staff assisted people without talking to them. For example, we saw one person being assisted to transfer from their wheelchair to a high backed chair in the main lounge. Staff completed the task with a minimum of instruction, explanation or reassurance. We saw people were not rushed by staff who were assisting them, although on several occasions we saw staff assisting people to move around the home and they did so in silence.

We observed practices which showed a lack of respect for people and undermined their dignity. This included the practices of senior staff and the provider which suggested these poor practices were part of the staff culture.

On two occasions when we were speaking with people we were interrupted by the registered manager who spoke in front of other people about that person's health and behaviours. When we were trying to engage with a person in the dining room over breakfast the registered manager interrupted to say, "She can't tell you her name, she's got dementia." When we were speaking to another person in the lounge the registered manager spoke across the room saying, "Careful if she grabs your hand. She spits, always spitting." These exchanges were not respectful of either person's dignity.

We spoke with another person who told us they were hard of hearing and we adjusted our voice accordingly. The provider remarked across the room, "She can never hear a word I say." This would indicate that the provider did not consider the person's needs when trying to interact with them.

We saw another person sitting in the lounge and their catheter bag was visible below their trousers. The person was trying to pull their trouser leg down to cover it and was clearly bothered by the bag being exposed.

We saw a staff member come on duty and they were talking to two people in the dining room. They were telling them it was cold outside and put their hands on people's faces. The staff member then said to one person, "I could put my hand down your boobies."

We asked people about routines around bathing, going to bed and getting up. One person said, "I can have a shower when they say." Another person told us, "It's usually in the afternoons that you have a bath. I have them about once a week – I find that adequate." A further person said, "They help me (with bathing). They come round and ask you – I always say yes when they ask." Other people told us they had some influence over routines but were vague in their responses. People said they could choose what time they got up and went to bed. We saw one person was already dressed and in the lounge when we arrived at 7.05am. They told us, "I always get up early, it's my choice." Another person said, "My wife isn't up yet, you can get up when you want."

However, we found staff did not always listen or act upon what people were saying and were not always responsive to people's needs. For example, we saw a person was brought into the dining room by staff and asked where they would like to sit. The person indicated a table in front of them, but the staff member said, "No, they're clean," and wheeled the person to a different table.

On another occasion, we saw a staff member went to move a person in a wheelchair from the breakfast table. As the staff member moved the chair, the person cried out in pain to which the staff member said, "What?" The person asked the staff member to put the foot plates in place and to make sure their feet were on them properly as one was catching under the chair. We saw this person was moved to the lounge in the wheelchair with no footplates on. The staff member asked the person to lift their legs and we saw the person had to keep their legs raised as they were transported in the wheelchair.

We saw another person was brought into the lounge by staff and assisted into an armchair then the staff left. We saw the person's feet did not reach the floor and they were lifting their legs up and looking around. We asked the

Is the service caring?

person if they were alright and they said they usually had a stool to put their feet on. The person said, "I want a stool for my legs. My feet don't touch the floor. The staff are always rushing and I didn't have time to tell them." We found a staff member who brought the person a footstool but this should have been provided when the person was brought into the room.

On another occasion we saw a person trying to attract staff attention for almost five minutes, but no-one went to them. We went over and spoke with the person who said they wanted to use the toilet. We asked a staff member to assist, but they said they were a cleaner. They went to find the care staff and returned telling the person staff would be with them in two minutes. Almost 14 minutes later a staff member came but was called away by another person. We then informed the registered manager who personally assisted the individual but by this time the person had been waiting a considerable time.

There was a noticeboard in the dining room with information for staff, although it was possible for people to see it and read what was posted on there. There was a poster about training for End of Life Care, which did not demonstrate any consideration for the feelings of people who may see it. This was not an appropriate location for such information.

We saw closed circuit television (CCTV) cameras were in operation at the service and one camera covered an area where people were sitting. We asked the provider if there was a policy and procedure in place and if people knew about the CCTV. They told us there was not but said they would move the camera so it was only covering the medication trolleys and not the dining area. When we returned on the second day we saw this had not happened and people using the service could be seen on the TV monitor. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At the last inspection in November 2014 we found some care records were incomplete, missing or not up to date. The provider's action plan stated all care plans would be updated by the end of March 2015 and new daily records introduced. The action plan also stated new computerised records would be started in March 2015.

The deputy manager showed us the computerised care record system which was being implemented. They explained this was not yet operational and they were currently using the Kardex system which had been in place at the previous inspection. They told us daily report records had been introduced to support the Kardex system. We reviewed people's care plans and the daily records and found there were significant shortfalls in the information provided. This meant it was not clear what people's care needs were or the support they required from staff to meet those needs.

We found there were still gaps on care charts as staff had not completed them. For example, one person's chart had only one entry on their health and hygiene chart for April 2015 and their night care chart had not been completed on five nights in April 2015. Care plans and risk assessments were not in place to cover all their needs. This person had no falls risk assessment despite the daily records showing they had fallen twice in February 2015. This person had a colostomy yet there was no care plan to show what support the person needed in managing this aspect of their care. We saw this person during our visit trying to attract staff attention unsuccessfully. We went across to the person who asked us for assistance as their colostomy bag was full and needed emptying. They were anxious and said they were worried 'it might burst' and pointed to the bag which was fully extended. We were unable to find any care staff and asked the registered manager to help which they did.

For another person their nutritional care plan had not been reviewed since January 2015, although records showed they were nutritionally at risk and they required a good nutritional intake for their pressure ulcer to heal. This person had some skin damage including a grade 4 pressure ulcer which had been seen by the tissue viability nurse in September 2014, yet we found care and treatment plans were not in place for one wound and had not been updated since 7 March 2015 for the pressure ulcer. We spoke with the deputy manager who confirmed the person still had a grade 4 pressure ulcer but did not know if the person still had the other wound. The deputy manager confirmed there were no dressing plans in place and said there should have been.

We saw from the accident reports one person had sustained skin damage to both legs following a fall in December 2014. We saw this person had large dressings on both legs. We looked at their care plan and although there were photographs of the wounds we could not find any wound care plans. We asked the nurse on duty what dressings were being used and how often they were being changed. They could not tell us. We asked them where a record would be made when the dressings were changed and they told us it would be in the daily records. However, when they looked at the daily records with us they could not find any entries relating to these dressings being changed. We spoke with the registered manager who told us there were no dressing plans in place but due to delayed healing they had made a referral to the tissue viability nurse. In the absence of records reporting on the dates, times, condition and size of the wounds it was not possible to ascertain whether any improvement had been noted.

A further person had been admitted for intermediate care with a history of falls and the accident records showed this person had fallen on 4 April 2015. There was no falls risk assessment completed and no entry in the care records to show that this person had fallen. When we spoke with the intermediate care nurse about this person they were unaware a fall had occurred. When we returned on the second day of our inspection we found this person had sustained a further fall. The physiotherapist told us that following feedback given on the first day of our inspection falls risk assessments were now being completed for all new admissions.

Another person's notes showed they had been admitted to the home in February 2015 from another care home. No assessments had been documented until a month after admission to the home and care plans were written two months after admission. We found information recorded in the care plan was incorrect. For example, the care plan stated this person needed some assistance with washing and dressing and needed encouragement to wear their hearing aid. Yet when we asked staff they told us this person needed the assistance of two staff to wash and dress and did not need a hearing aid. This meant the care

plan was not accurate or personal to this individual. We spoke to the deputy manager about this and they told us the care plans were generic and information was added or taken away to try and make them personal to the individual. They acknowledged the mistakes in this care plan.

We saw the care plan informed staff this person needed to drink 1500mls of fluid each day. We asked the deputy manager for the fluid charts so we could check this was happening. No fluid charts could be found. We saw from the review notes from the previous home this person would not ask for food or drink and needed full assistance from staff. We saw in the daily records night staff had recorded, "Not passed urine and may be constipated." This would indicate the person had not had sufficient fluids the previous day. When we looked in this person's bedroom we saw staff had been recording when incontinence pads were being checked and whether they were wet or dry. We asked the deputy manager about this and they told us checks had been made as the individual was not passing urine sometimes. The deputy manager said staff should be monitoring this person's fluid intake and maintaining a fluid balance chart. We looked at this person's bowel chart which indicated they had not had their bowels opened over a nine day period. We looked at the medication administration records and saw staff had recorded that the medicine they were prescribed for their bowels had been refused on seven of the nine days. This meant the person was not receiving the medicines they required.

We met with one person in their bedroom and saw their toenails were very long and thick. The person said, "They're terrible aren't they. I can't walk on them." When we asked the person if they had been seen by a chiropodist, they said, "No, but I need to they're awful." We looked at this person's care records and saw an entry dated 8 April 2015 which stated; "Toe nails are very long and need cutting." We looked at the multidisciplinary record sheets dated from 16 October 2014 to 22 April 2015 and no chiropody treatment had been recorded. We asked the registered manager about this and they told us, "The owner is struggling to get hold of a chiropodist."

Another person's records we reviewed showed they were catheterised and were prone to urine infections and the catheter blocking. Daily records in March and April 2015 noted the person's urine was 'dark' which indicated the person may not been receiving enough fluids. The care plan stated to 'encourage good oral intake' and 'knows needs to drink plenty', however there was no target fluid input or output to guide staff. We asked the nurse how they ensured the person received sufficient fluids and they said staff were allocated to "push fluids and monitor output" when we asked where this would be recorded the nurse said, "I would hope all have fluid balance charts." We found there were no fluid charts for this person. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no daily activity programme advertised in the home, although there were fliers advertising visiting entertainers.

On the first day of the inspection, entertainers came in the afternoon and we saw people smiling and joining in with the singing. One person said, "That was lovely."

We arrived at 7.05am on the second day of our inspection. Two people were seated in the main lounge and the television was on showing a shopping channel. This channel remained on until the majority of people had had breakfast.

We did not see any proactive activities undertaken in the home. People were unenthusiastic when we asked what there was to do. Although several referred to the entertainers who occasionally visited, there was little reference to anything arranged in the home. One person said, "We just sit and do whatever we can find." Another person said, "There is lots' going on. I play cards and food takes up a lot of time." A further person said, "What gets me is that you don't do anything. You sit in that room (the lounge) all day. They just leave the television on and you watch what they put on." Another person told us, "Sometimes we have singers. Yesterday a lady came to do Zumba, but I don't bother with that. Generally there's not much to do, just watch TV." One person said, "The girl that used to do bingo has left. Sometimes a carer might do it but not very often. There's not much going on to join in with."

Visitors we spoke with felt that there were some activities though they had not witnessed these. One visitor said, "I think there's quite a bit going on. They have entertainers and play bingo."

During the afternoon the television was quite loud and there was a great deal of ambient noise from footfall on the solid floor and staff talking, mainly to one another. One

Inadequate

Is the service responsive?

person was seated close to the television and next to the area of the lounge which was also used as a corridor leading from the front door to the dining room. This person told us, "I'd be alright here if it wasn't for this noise. While I've been here it's so noisy as people pass – I think they've been trained to stamp their feet as they pass me."

We asked people if they knew what to do if they wished to make a complaint, most could not tell us about any formal mechanisms for doing so, but all were able to tell us what they would do. No one felt that they would not be able to speak to either the staff or the manager. One person said, "If I was worried about anything I'd talk to one of the people that work here." Another person said, "I would talk to (the registered manager) if there were any problems." A further person said, "I'm not sure what I would do if I wanted to make a complaint – I've never wanted to. I'd probably speak to the manager."

Inadequate

Is the service well-led?

Our findings

At the last inspection in November 2014 we found there was a lack of formal systems to assess and monitor the quality of care. The provider's action plan stated 'numerous audits will be implemented to ensure the efficient and safe running of Park View Nursing Home' and that these would be in place by February 2015. When we met with the provider in March 2015 they confirmed all the actions in the action plan had been completed and the service was compliant.

The home had a registered manager. However, the provider informed us during the inspection the management arrangements were being changed and the deputy manager would be taking over as the manager of the home. People we spoke with who could identify the registered manager told us they saw her regularly and found her approachable. One person said, "I see (the manager) around quite a lot." Another person said, "You see the manager walking about. She's nice and approachable."

We found ineffective communication systems and poor organisation meant nurses and managers were often unaware of what was happening in the home. For example, not all staff were aware a person had been discharged form hospital with an infection. This was not identified to staff in the handover which meant effective infection control procedures were not put in place to keep people safe. Intermediate care staff told us communication needed to improve between staff working in the home as well as with staff in the intermediate care team. They gave us an example where the intermediate care nurse had spent all morning trying to arrange a GP visit for one person only to discover the registered manager had already made the appointment. In another example, intermediate care staff had had to contact relatives to ask them to bring in equipment from home for a person's PEG feed as staff had failed to order sufficient supplies. We saw ambulance staff arrived early in the morning to take an intermediate care person to an eye appointment at 8am. Although the registered manager knew about the appointment, none of the other staff did and the person was not ready when the transport arrived. The ambulance driver said they had been told an escort would be provided but this had not been arranged. The intermediate care nurse told us staff from the home did not attend the weekly multi-disciplinary team (MDT) meetings which meant there was a reliance on the intermediate care staff passing on any information and there was no input from the home staff.

We found the systems in place to assess and monitor the quality of service provision were ineffective and had failed to identify and address the serious issues and concerns we identified at this inspection.

On the first day of the inspection the deputy manager and provider were unable to locate the accident records covering the period from September 2014 to the beginning of April 2015. On the second day of out inspection the missing accident book had been found. We looked at the entries from 6 December 2014 to 6 March 2015. We saw 26 falls had been recorded as taking place in people's bedrooms that had been unwitnessed by staff. We asked the provider if they completed any analysis of the accidents and incidents and they told us they did not. This meant they were not monitoring or reviewing accidents to identify any common themes or trends and taking action to reduce the risks to individuals.

We asked to see care plan audits and we were told by the deputy manager that none had been done. The provider told us there were no environmental risk assessments and there was no dependency tool to calculate staffing levels.

We spent time with the deputy manager who the provider told us was implementing the improvements stated in the action plan. The deputy manager told us they were now supernumerary, although they sometimes worked a shift on the floor. They said their main focus had been in making improvements in medicines and care planning. A new computerised system had been installed two weeks prior to our inspection, which was going to be used for people's care records, staff records and audit purposes. The deputy manager told us they were inputting all the information onto the system and had put 25 people's details on so far.

The deputy manager told us they were setting up new training files for staff, had started to complete staff appraisals and were beginning to plan in supervisions. They said they were also planning to update all of the home's policies and procedures, were delivering the induction programme to new staff and were organising all

the training. The deputy manager confirmed there was no planned programme to prioritise or implement these improvements. They acknowledged it was a huge task, but felt it would all be in place within the next three months.

The provider's action plan stated all the home's policies and procedures would be updated by the end of March 2015. The deputy manager told us the medicine policy had been updated but all the other policies and procedures were the same as when we had inspected in November 2014. We saw the policies and procedures were from the Registered Nursing Homes Association and were dated September 2010.

When we spoke with people their awareness of residents' meetings was low, and we did not see any information about these meetings on display in the home. One person told us, "We don't have meetings and no one comes to ask us what we think (of the home)." A visitor said, "We do get involved in the meetings – the next one is in June." When we asked if there was anything which they felt had changed as a result of the meetings they said, "Some relatives did not realise that you can take you family member away if you want – when we said we were taking my family on holiday they were surprised that this was allowed." One person said, "The management don't like me because I speak my mind. I'm always in trouble." People were not aware of any surveys or other means of capturing anything other than anecdotal feedback from them.

The provider showed us surveys which had been given to people to gain their views of the service. We saw three surveys completed by people in January 2015. One survey showed the person said their mattress was lumpy, when we asked the provider what action had been taken in response to this they said they did not know. We saw five questionnaires had been completed by people about the food. These were composed of tick lists of likes and suggestions for foods people may like to see on the menus. We saw one person had asked for fish, new potatoes and broccoli, another person chillies and curries and a further person had asked for ham and pineapple pizza. We looked at the new menus and saw none of these options had been included. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw minutes from a residents and relatives meeting held on 10 March 2015. The minutes showed topics discussed included residents life histories, menu planning, personal allowances and care planning. The provider told us that a copy of the report summary of the inspection in November 2014 had been posted out to relatives and also a disclaimer form with different options for relatives to be involved in care plan reviews. The minutes showed a further meeting was planned for June 2015.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (1) & (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as the management of medicines was not safe and proper; and the risks in relation to the spread of infection were not assessed, prevented, detected or controlled. Regulation 12 (2) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed and had not received appropriate support, training, professional development, supervision and appraisal to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises used by the service provider were not secure or properly maintained. Regulation 15 (1) (b) (e).

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 18 (1) (a) (b) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Accurate, complete and contemporaneous records were not maintained in respect of each service user, including a record of the care and treatment provided to the service user and decisions taken in relation to the care and treatment provided. Regulation 17 (1) (2) (a) (b) (c).