Park Vista Care Homes Limited

# Park Vista Care Home

## Inspection report

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Tel: 01733555110

Date of inspection visit:
14 June 2016
15 June 2016

Date of publication:
26 July 2016

## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Good** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

Park Vista Care Home is registered to provide accommodation for up to 59 people who require nursing or personal care. The home provides support for older people, some of whom are living with dementia. Accommodation is provided over three floors. The upper floors can be accessed by stairs or a lift. There are many places where people can sit on their own or with visitors in private without going to their bedrooms. There are some large communal areas such as the conservatory and sitting rooms that could accommodate larger groups. At the time of our inspection there were 54 people living in the home.

This unannounced inspection took place on 14 and 15 June 2016.

The service did not have a registered manager. The last registered manager left their position in October 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. The provider had appointed a new manager but they had not yet applied to become the registered manager with CQC.

People were not always supported to take their medicines as prescribed and medicines were not always safely managed.

Procedures in place to check the quality of the care provided had not always identified issues in relation to the completion of food and fluid charts, re positioning charts and people's daily note records.

An effective induction process was in place to support new staff and further training was provided to ensure all staff had the necessary expertise and skills.

People were involved when their needs had been assessed and reviewed so that staff knew how to provide the care and support they needed.

The risk of harm for people was reduced because staff knew how to recognise and report abuse. There was a sufficient number of staff to meet the care and support needs of people living in the home. Satisfactory pre-employment checks were completed before staff worked in the home.

People were supported to be as safe as possible because assessments of risks had been completed and included details of how the risks could be managed. This meant staff had the information they needed to reduce risks.

Staff were trained in the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and could describe how people were supported to make decisions.

People had sufficient food and drink of their choice throughout the day. People were supported by kind, caring and happy staff. People's privacy and dignity was respected by staff.

Feedback and information from people, staff meetings and other meetings were used to monitor the quality of the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

People were not always safe because staff had not followed the provider's policies and procedures in administering medicines that had been prescribed 'when necessary.'

Risks to people's safety and welfare were assessed and managed.

There were enough staff to provide the necessary care and support for people.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's healthcare needs had not always been effectively addressed.

People had individual menu choices, which meant their health and nutritional needs were effectively met.

People received care from staff who were trained and supported to provide safe and appropriate care. Staff knew the people they cared for well.

People's rights to make decisions about their care were respected.

### Is the service caring?

**Good**

The service was caring.

Staff were kind and treated people with dignity and respect.

Friends and family of people living in the home were encouraged to visit at any time.

People and their relatives were involved in decisions about their care.

## Is the service responsive?

Good

The service was responsive.

People knew who they could speak with if they had a concern or complaint. A complaints procedure was in place and the manager responded appropriately to people's concerns or complaints.

People had their care needs assessed and staff knew how to meet them.

## Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in place.

There were systems in place to continually monitor and drive improvement of the standard and quality of care that people received. However, audits completed were not always robust. People's records were not always completed in full or accurately by staff.

The manager was experienced and staff were trained to provide people with safe and appropriate care.

# Park Vista Care Home

**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 unannounced inspection took place on 14 and 15 June 2016. It was undertaken by one inspector.

Before our inspection we looked at all the information we held about the service including notifications. A notification is information about events that the registered persons are required, by law, to tell us about. We also asked for feedback from the commissioners of people's care and local authority safeguarding team.

Before the inspection, the provider completed 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.

During our inspection we spoke with nine people and two relatives. In addition to the manager, we spoke with the senior care manager, one nurse, two senior care assistants, one care assistant and a chef. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at ten people's care records, four staff recruitment records, staff training and supervision records and other records relating to the management of the service. These included audits, rotas and meeting minutes, complaints investigations and policies and procedures.

Requires Improvement

# Is the service safe?

## Our findings

People were not always kept safe because nurses had not followed guidelines when administering medication that was prescribed to be given "as required". During this inspection we found that one person had been administered a medication 38 out of 39 nights from 7 May 2016. The medication should only have been given when necessary. However, we found that there was no written documented evidence as to why the medication had been administered by the nurse. This was not in line with the provider's policy and procedure for the administration of "as required" medication. We spoke with the manager about this. The manager then wrote a protocol during the inspection to give clear guidelines on when nurses should administer the particular medication and what records needed to be completed.

People told us they were happy with how their medicines were administered. One person told us, "They [staff] bring in my medication as I'm on loads of tablets. They give them exactly right [with water and on time]. They bring me pain killers if I'm in pain." In one person's care plan we saw how a recognised pain scale was used to identify when the necessary pain relief was required. This scale used visual expressions and staff had also recorded how other changes in the person's behaviour could show that they were in pain. We saw medication administration record (MAR) charts where a person could have one or two tablets, such as paracetamol. Staff had noted the number administered. This reduced the risk that people did not have too many tablets within a 24 hour period.

Not all accidents and incidents were recorded and investigated. We found details in the daily notes that showed staff had been injured by people and the details had not been recorded as incidents. The manager said they had not been informed and therefore had not been able to investigate the incidents. As a result people may not have received the care they needed since their actions had not been investigated or referrals made to the appropriate health care professionals.

Staff said any measures required to help minimise the potential for any recurrence such as a person falling or behaviour that challenged the person or others was recorded. For example, there was evidence that referrals were made to the local falls team, and psychiatric services. We also noted that a request for the provision of additional equipment such as bed rails had been provided. The manager said the daily notes would be checked, all incidents formally recorded and any measures put in place to protect people and staff.

People told us they felt safe. One person said, "No-one can get in here [the home] without ringing the door," and another said, "If you want anybody [staff] they're not long in coming".

Information from the provider showed, and staff confirmed, that they had undertaken training in safeguarding people from harm and were able to explain the types of harm and the process to be followed when incidents of harm occurred. One staff member said, "I am due to do a refresher soon [training in protecting people from harm]. I would report anything to the manager. It would be dealt with but I could take it further to our head office or CQC." The staff member said all staff had information available about protecting people from harm, such as the phone numbers that they could use to report concerns. Another

member of staff said, "I would report to the manager straight away. I would record everything." We saw evidence that the manager had followed the provider's procedure in protecting people from harm through the investigations and outcomes that had been recorded. This included the two concerns that were raised during this inspection.

Staff told us that the home had a policy in place in relation to 'whistleblowing' which was where staff reported any poor practice. One staff member said, "Whistleblowing is if you think its wrong [staff behaviour or practice] and you whistle blow to the management or above." Another staff member said, "I am confident to do that [whistle blow] and it would be dealt with."

Information about how to report any incidents of harm was displayed in areas of the home that were accessible and where people could see them, as well as for staff and visitors. This showed us that that there were systems in place to help ensure that people were as safe as practicable.

Overall the level of risk to people was managed effectively. Areas of risk for people had been identified. The risks included moving and transferring, behaviour that challenged people and others, safe eating and drinking, the development of pressure sores and falls. We saw information in relation to how these risks had been managed. For example, one staff member told us about a person whose behaviour can challenge themselves and others and said, "I give time, leave, come back and then [person's name] is okay. I tell [person] it's safe here, you're okay, no-one will hurt you." We saw that a process was in place so that risks were reviewed regularly, although we noted that information on the risk on one person had not been updated. Staff confirmed that reviews took place, that they were informed of the updated information and people's records were updated where necessary.

People and their relatives told us that when people were supported with their care needs this was done in a safe way. For example, where two staff were required for safe moving and transferring of a person, the correct number of staff were always provided. Our observations of people, who were moved and transferred, showed that staff made sure people were assisted as safely as possible. One person commented, "It's quite an adventure [when they were hoisted]. They [staff] don't hurt me and I'm not frightened."

Records showed that appropriate equipment maintenance and servicing had taken place. The fire alarm system was tested weekly and fire extinguishers and emergency lighting were checked and serviced regularly by a contractor. There were Personal Emergency Evacuation Plans which were easily available in an emergency. These provided emergency services with information about each person living in the home and the level of assistance needed in the event of an emergency evacuation such as a fire. There were detailed business contingency plans in place and staff were aware of where these were kept. This meant that in the event of a foreseeable emergency staff would have the appropriate information to act promptly.

The manager said they talked with the nurses each week to establish any changes in people's needs. This was then used to check the staffing levels required to ensure people's needs could be met safely and effectively. People and their relatives told us that there were sufficient numbers of staff in place to meet people's care needs. One person told us, "There are enough staff, there's always someone [staff] popping by."

People were safe because the provider followed robust procedures for the recruitment of staff. Staff confirmed that checks that had been completed before they began working with people in the home. For example, a satisfactory employment history and Disclosure and Barring Service (DBS) check, (this check is to ensure that staff are suitable to work with people who use this service). Staff said that they had provided other documents which included recent photographic identity and a declaration of their health status.

Requires Improvement

# Is the service effective?

## Our findings

Nursing and care staff told us that they supported people to access healthcare professionals including GP's, dieticians, speech and language therapists and community nurses. Staff were clear and understood their responsibilities and there were procedures in place to support people's healthcare needs. However, we found that people's healthcare records had not always ensured effective action to be taken. For example, although people were weighed regularly, the records had not always been updated by the nurses. As a result we found that one person had moved from a low risk to a medium risk of malnutrition when using the Malnutrition Universal Screening Tool (MUST). However, there had been no suitable dietary action taken or input from health professionals because no-one had updated the person's weight record and MUST. This showed that people's healthcare needs were not always responded to in a timely manner. The manager said that all weight records and MUST would be updated that day.

One person said, "I have had the doctor recently as I had a [medical condition]." Another person told us they saw the chiropodist but could "do with seeing them again." One relative said, "The staff are really good. They ring me if [family member] isn't well or needs me."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The staff had a good understanding of the MCA and DoLS and confirmed that where people using the service had or did not have capacity, information was in their care plan. We saw that staff understood people's needs well. This was by ensuring that the care provided was only with the person's agreement and in line with the MCA and DoLS codes of practice. A member of staff told us, "You ask people and offer choice. You try to explain everything to them and if they don't want something you don't force it on them."

We found that appropriate applications to lawfully deprive people of their liberty had been submitted to the supervisory body [local authority]. Some had been agreed and others were awaiting authorisation.

We checked information that had been recorded in relation to any incidents to ensure people were not restrained. We found that no-one had been restrained and staff and management confirmed that was the case. Information in people's care plans and risk assessments showed that staff had details of how to de-escalate situations. For example, by offering people reassurance, leaving a situation to return a short while

later or by conversing with people.

Staff told us about the induction training programme, which provided all the mandatory training expected by the provider. One new member of staff said, "I have done all the training. I did shadow shifts [where staff work with a more experienced member of staff]." Information about staff training was kept on the computer. We saw that all mandatory training expected by the provider was up to date or had been arranged for all staff.

People were supported by staff who had the knowledge and training necessary to meet their needs. Staff told us they received a range of training that supported them with their roles. These included safeguarding people from the risk of harm, dementia awareness, continence care and moving and transferring. One person said, "They [staff] know what they're doing."

Staff told us that they were supported by face to face supervision meetings, group supervision and staff meetings. One staff member told us, "I get regular supervision from [name of manager and name of senior supervisor] and I'm due my [annual] appraisal." Nurses said they received clinical supervision from the manager. Staff said the group supervisions were used to inform all staff of any changes in good practice such as hand washing.

We saw that people had access to refreshments and snacks throughout the day. People were supported to eat and drink the foods they liked, how and where they liked to eat them and any particular dietary needs. One person told us, "I've just had a cooked breakfast. I really enjoyed it." Another said, "I eat in my room. It's my choice." Although people told us they did not have a choice of food at mealtimes, we heard discussions between the chef and several people in the home about specific foods that were available for them. One person asked to check if their particular cheese was in the fridge, whilst another was offered a different lunch meal as the chef knew they did not like the lunch menu. On the day of inspection we saw that the chef went to the local shop as one person wanted an ice cream. People said they "only had to ask" and the item would be provided. One relative said, "I've even smelt kippers when I've come in in the morning."

People were supported to eat their meals if needed. Where people had a soft food or pureed diet we saw that they were assisted (if required) to ensure they had sufficient to eat and drink. We saw that staff, who helped those people to eat their meal, did this at a pace the person was comfortable with and explained the food they were being given.

Good

# Is the service caring?

## Our findings

People were positive about the way that staff treated them. One relative said, "They look after him well." One person said, "They [staff] look after you pretty well." Another said, "The staff are absolutely brilliant." In one lounge we saw that some staff interacted with people in a way that was inclusive and positive. The positive outcomes for people were visible. People perked up, started chatting and were generally more involved in conversation. One person told us, "She's [staff member] lovely. She can sing and dance."

People said that staff treated them with dignity and respect. Staff described and people confirmed various methods they used to help support people with their privacy and dignity. This included closing a door with a sign on the handle showing that care was being provided, letting people do as much of their personal care as possible and that staff knocked on their door, even though the door was open. We saw that where people required help to transfer from a wheelchair to another chair, the staff were very careful to ensure the person's dignity by covering them if they wore a skirt for example. The staff spoke quietly to the person and explained exactly what was to happen and made sure the person was ready before they were moved. At any time a drink was offered a staff member asked people for their choice of drinks, which were provided. One person told us how staff assisted them with their personal care and said, "I get the help I need."

People were assisted by staff to be as independent as possible. Staff were able to describe what areas people were independent with, as well as how to provide their care. One relative told us their family member was encouraged to dress themselves, even if the clothing "was not always right." Staff then made suggestions to ensure the person was dressed appropriately.

People were able to speak up on their own behalf or were supported by a relative who would speak up for them if it was necessary. Staff said that an independent advocate would be sought to help anyone if they wanted it. Information about advocates was displayed on notice boards in the home. This was to help those people or families who may wish to request external help and information. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People had care plans that identified how they wanted their care to be provided. This included what the person's preferences were such as spending time in their room or being part of activities that would interest them. One person told us, "I prefer to stay in my room. I enjoy watching TV and have visitors." We observed that when people were asleep and drinks were provided or meals were served, staff were gentle when they woke people and quietly asked them if they wanted a drink or to go for their meal.

Arrangements were in place to support people and their relatives to be as involved as possible in the person's care. Examples we saw included staff's day to day conversations as well as more formal reviews. Opportunities were taken by staff to give people the explanations they needed such as why staff provided personal care. A relative said, "We visited before [family member] came here. [Family member] has settled well and had their first review. The staff contact us if there are any issues."

People told us that they were supported in a way which meant the risk of social isolation was minimised. For

example, there were several visitors and relatives who visited during the inspection. The manager and staff also encouraged people to get out into the community as well as into the home's gardens. One person told us, "I love being in the fresh air, but I do need staff with me." Another person told us, "I get taken out by [relatives] to family events or just out." People told us they had a picnic in the local park, which they had really enjoyed.

Good

# Is the service responsive?

## Our findings

Records showed that the manager assessed people before they came to live in the home to ensure their care needs could be met. The information in the assessments formed the basis of people's initial care plans so that staff could work with people's needs. This ensured that staff were able to respond to people in a way that provided the care they needed. Records we viewed confirmed this.

Some people said they were aware of their folder or care plan, but not everyone had looked at or had been involved in it. One person said they had a care plan, but had not been involved. However, when we looked we saw that the person had been involved and signed to confirm they agreed with what was written. Another person said, "There is a care plan but I haven't bothered to look at it." We saw that people had been involved where possible, and if not relatives had been spoken with so that staff had up to date information in how to provide good care for people. Staff had access to information about specific illnesses, which had also been placed in people's files.

People's care needs were reviewed regularly and, where there were changes in those needs, the individual plans of care had usually been updated. For example, we saw that one person now only needed one member of staff for their personal care needs. Information in the plan showed the changes for the staff requirements in relation to personal care. This meant that people's changing care needs were recognised and that staff had the updated information they needed to provide good care.

People told us about the activities they enjoyed, such as a recent garden fete, musical entertainers, trips they had been on and games that took place in the home. People also told us they sometimes liked to spend time in their own bedrooms to watch TV or read books or magazines. One person said, "They [staff] ask me if I want to go down to take part, but I choose not to." We saw that a list of weekly activities were in each person's bedroom. Although one person said, "There's nothing to do. It's not adequate if you are able," we saw that there are coffee mornings, sociable club meetings, games, individual time and bingo. We saw the person who arranged activities and during the inspection they sat and talked with people, encouraged people to take part in games and assisted people with meals. The staff member said that people did go to the local park when the weather was suitable, or in the garden of the home.

Information from the provider showed that there was a complaints policy and procedure in place. Although people were not necessarily aware of a complaints procedure, they and their relatives were able to identify a way to make a complaint. One person said, "I would talk to [name of manager]. She will sort anything out." Another person said, "If I wanted to complain they'd know it." One relative said, "If I wasn't happy I would talk to the nurse, [name of the manager]or the provider." Staff confirmed how they would support people to make a complaint if that was necessary. We saw that there was a policy and procedure in place from the provider on how to deal with complaints and this had been followed. There had been 12 complaints which had been recorded, investigated and actioned to the satisfaction of the complainant.

Requires Improvement

# Is the service well-led?

## Our findings

Although audits of food and fluid charts, repositioning charts and daily notes had been completed, we found a number of issues during the inspection. The manager said that a random sample was checked each week to check the quality of the records and to take any action when necessary.

People deemed to be at risk were not always protected on the first floor of the home because records such as food and fluid charts had not been fully or accurately completed by staff. This limited the provider's ability to recognise if any person had or had not had sufficient food to eat or fluid to drink. However, on the ground floor we saw that the food and fluid charts were being completed more accurately. The manager was informed during the inspection and took action so that people's fluid goals were recorded and their daily intake was totalled. We saw that this had been completed the following day.

Details of repositioning charts were not fully completed which meant people deemed to be at risk may not be moved to ensure their skin remained intact. For example, on one chart it showed the person should be moved every '2/4 hours'. The manager was not able to explain what that meant especially as the different gaps between repositioning were varied. We saw that the person did not have any pressure sores but there were times when the gaps between changes were up to six hours.

We saw that people's daily notes had not always been completed, which meant we were unable to know how people had been cared for, what frame of mind they were in or their health or wellbeing needs. There was no information in the hand over sheets to show that the nurses had recognised the problem or done anything in response to it.

At the time of the visit, Park Vista Care Home did not have a registered manager in post. The last registered manager left the service in October 2014. A manager was in place to manage the home on a day to day basis, supported by a senior care supervisor and representatives of the provider. Staff said the manager had made improvements to the service. One staff member said, "Since [name of manager] has come the home is going up [improving] and we are trying to improve the quality of care." Another said, "[Name of manager] is trying to do what's best but I'd like to see her on the floor more. The ways she's doing things is good." Another staff member said, "The manager is really supportive, but there have been lots of changes very quickly. Some changes are really good."

People were involved in improving and developing the service through informal chats with staff and the first residents' meeting was to take place in July 2016. During the inspection we heard how one person was asked to attend an activity with a new entertainer (musician) who was due to visit the home. Staff asked the person to feed back (as the person had provided feedback about other entertainers) to see what the feeling around the home was. The person said they were very happy to oblige as they had done previously. People told us that staff asked them about quality of the care provided in the home. One relative said they had received a phone call about the care their family member received.

Staff team meetings were held regularly and staff said they were expected to attend unless they were

providing care. They said they were encouraged to discuss general themes such as any changes to the service people received. One staff member said, "We discuss everything. If there's something about health and safety then [name of health and safety person in the company] comes to the meeting. If there are changes we want to see are discussed as well as any concerns." There were heads of departments meetings each weekday to check if there were any issues that needed to be addressed urgently. The senior care supervisor said the meetings worked and made sure small issues were addressed quickly. There were monthly senior meetings.

Records we held about the service showed that notifications had been sent to the Care Quality Commission (CQC) as required. A notification is information about important events that the provider is required by law to notify us about. This showed that the manager had an understanding of their role and responsibilities.