Parkview Care Homes Limited

Parkview Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Parkview Care Home is a residential care home providing personal care and support to people experiencing complex or enduring mental health difficulties. The service can support up to 10 people. At the time of inspection there were eight people living at the home, one person was receiving personal care. This is help with tasks related to personal hygiene and eating.

Parkview Care Home accommodates people in one adapted building across four floors. The building is in a residential area of the city close to public transport and public recreational areas.

People's experience of using this service and what we found
Areas previously found to require actions and improvements to meet fire safety regulations had been carried out. However, people's personal safety in the event of a fire was not clearly risk assessed or recorded.

There was a lack of management action to ensure improvements identified from provider audits were addressed. This included home hygiene, maintenance and care plan reviews.

Infection prevention and control was not always well managed. Some areas and facilities had been improved and decluttered. However, other communal or shared areas remained unclean, in need of deep clean or repair.

Staff had not received all the training they needed to support people safely, for example to manage fire risks, use of equipment and safeguarding people from harm.

Care and support plans and risk assessments had not been kept up to date and were not person centred. People's individual needs and plans were not accurate or sufficiently detailed.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support best practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was inadequate (published 5 February 2022) and there were breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced inspection of this service on 26 October 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what

they would do and by when to improve. We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements.

At this inspection we also checked whether the Warning Notice we previously served in relation to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met regarding specific concerns we had about fire safety.

The overall rating for the service has remained inadequate. This is based on the findings at this inspection.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We found the provider had taken the required fire safety actions in regard to the Warning Notice we previously served. We found continuing breaches in relation to safe care and treatment, person centred care, premises and equipment, good governance and record keeping.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Parkview Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Parkview is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received from and about the service since the last inspection and we

gained feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with one person who used the service about their experience of the care provided. We spoke with three members of staff and a senior manager from head office. The service's registered manager was not available at the time of inspection.

We spent time observing how people and staff interacted and we observed how medicine was managed with people. We reviewed a range of records including safety and maintenance records and provider audits. We looked at three staff files in relation to recruitment and staff supervision, we looked at one person's care plan.

We sought clarification from the provider to validate evidence found and establish what actions they were taking to address concerns found. We spoke with a social care professional who has had recent contact with the service. We spoke with the local authority to clarify information.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

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

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

● Areas which we identified for improvement at the last inspection had not been actioned. For example, a shared bathroom was dirty and required repairs; and stair carpets doors and walls required cleaning. We found areas of risk which needed repair such as a split wooden banister which could cause splinters and a raised threshold to the laundry area which was a trip hazard.
● A cleaning schedule had been put in place, however, cleaning tasks were not completed according to the schedule. Cleaning tasks in some communal areas, such as toilets, were not completed daily.
● Fire safety improvements had been made to the structure of the building and cluttered areas had been cleared. However, one person who required specific support to exit the building, and with equipment in the event of a fall, did not have assessments or plans in place.
● One person's specialist lifting equipment was wrongly identified in their care plan and staff had not been trained in the use of this equipment.

The provider had failed to ensure the premises was properly maintained, standards of hygiene upheld and health and safety risk assessments acted on. This placed people at risk of harm. This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately to ensure correct lifting equipment was identified and training was in place for staff.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

regulation 12.

● A significant accident experienced by a person living at the home had not been recorded in the incident and accident log and had not been reported to CQC. Due to incomplete record keeping of incidents and accidents we were not assured that all accidents and incidents were being recognised, recorded or responded to appropriately.
● One person whose mobility had significantly changed, did not have clear risk assessments or actions in place in response to increased needs and risks. For example, they were facilitated to smoke in their room with a member of staff present. However, there was no risk assessment or plan in place to identify and mitigate fire risks, identify use of fire safety equipment or staff actions to reduce risk. Steps had not been taken to respond to their reduced access to the home or community, or to reduce isolation.
● Where a person smoked and made use of emollient cream, this had not been subject to risk assessment or plans to reduce risk of combustion. Staff had not received training in reducing risks in the use of emollient cream.
● One person who was at high risk of developing diabetes had no robust plans in place to identify and monitor risks associated with their condition such as weight and skin health. Staff provided support with all meals and topical creams but did not have dietary guidance to follow or body maps to refer to. There was no system in place to identify if the person's weight or skin health changed and required medical advice.

The provider had failed to ensure that people were protected from the risk of avoidable harm. Although there was no evidence people had come to harm, they were at increased risk. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately by reviewing and updating the person's risk assessments regarding use of emollient cream and providing training to staff in safe practices.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were not always enough staff working with the right mix of skills to meet people's needs. There was usually one member of staff working alone at night. If additional or emergency support was required, this member of staff was required to contact staff from the service next door.
● Staff gave us examples of regular short staffing. For example, when a member staff supported a person to attend an appointment and the second member of staff needed to respond to an emergency. This left no care staff to support tasks such as meal preparation, medicine or emotional support.
● Basic induction training such as fire drills and use of lifting equipment had not always been provided for staff. Staff refresher training for knowledge and skills to keep people safe was not up to date, such as fire safety, moving and handling and safeguarding.

The provider had failed to ensure there were sufficient numbers of suitably trained staff. This placed people at risk of harm. This was a continuing breach of regulation 18(1) (Staffing) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

These concerns were highlighted to senior management to follow up and make improvements.

At our last inspection the provider had failed to ensure safe recruitment processes were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● The provider did not have a robust recruitment process. Safe recruitment practices had not been followed and records of recruitment not complete. Records showed missing interview information, gaps in DBS checks and gaps in the induction process.
● Recruitment records were not accessible to relevant people when required. On the first day of the inspection, staff recruitment records were not accessible and could not be shared. This necessitated a return visit to the provider's other location where the records were stored.

The provider had failed to ensure safe recruitment processes were operated effectively. This was a continuing breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Senior managers told us they would review recruitment records and identify a plan to make improvements.

Using medicines safely; preventing and controlling infection

At our last inspection the provider had failed to ensure the proper and safe management of medicines and the control and prevention of infections. Although there was no evidence people had come to harm, they were at increased risk. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider's environmental audits had continued to identify actions for improvement in the cleanliness of the environment since our last inspection. However, these had still not been actioned. We continued to see unclean communal areas and unhygienic sanitaryware in bathrooms.
● Infection prevention and control measures were not consistent or robust. There was a cleaning schedule in place and agency staff had been arranged to complete tasks, however there were regular gaps in cleaning tasks being completed.
● Temperature of the medicine storage cupboard was not being monitored effectively. There was no record of the highest and lowest temperatures of the cupboard to establish if temperatures remained within safe limits at all times. This meant there was no system to ensure medicines were stored at recommended temperatures and not subject to temperatures which might make them less effective.
● During our first visit we saw that medicine room keys had been left unattended by staff and were found by a person who lives at the service. By the end of our visit this had not been recorded as an incident.

The provider had failed to ensure the proper and safe management of medicines and the control and

prevention of infections. Although there was no evidence people had come to harm, they were at increased risk. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was no facility for people to store temperature-controlled medicine if this was prescribed. We did not identify this as an immediate need, however, at the time of inspection the service was unprepared for temperature-controlled medicines and had no plans for where these could be stored. Following our inspection, the registered manager reviewed advice about the storage of temperature-controlled medicines and assured us they would purchase a fridge for medicines, if and when required.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Safeguarding training was not robustly managed. The provider had mandatory training in place for safeguarding awareness but not all staff had completed this.
● There were safeguarding policies in place, however not all staff had read these. Staff we spoke with could describe different forms of abuse, they felt confident raising safeguarding concerns and knew how to do this to the manager.

During our inspection, we raised these concerns to the provider and senior managers, who arranged a review of the concerns to develop an action plan for improvement. A person's care plan we had highlighted for improvement was reviewed and updated.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

At our last inspection, the provider had failed to provide staff with appropriate support, training, appraisal and supervision to carry out their role. This placed people at risk of receiving care and support which was not effective. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Staff had not all undertaken the mandatory or specialist training they needed. Some staff had not completed safety training or refresher training to ensure their knowledge was up to date and that they understood how to follow procedures. This included a lack of training supporting people's emotional needs, first aid and fire safety.
● There were incomplete records for staff's induction records. Staff told us they had completed some training but did not have an induction. We saw records showing that staff had not all accessed key policies and procedures such as safeguarding, whistleblowing and fire safety.
● Staff had not completed training in the use of specialist lifting equipment or safe use of emollient cream.

The provider had failed to provide staff with appropriate support, training, appraisal and supervision to carry out their role. This placed people at risk of receiving care and support which was not effective. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns with senior managers who told us they would review staff training and record keeping in order to make improvements. Steps were taken to ensure training was provided to staff for use of equipment and emollient creams.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to eat and drink enough to maintain a balanced diet
● People's care records did not reflect their goals or future plans, and did not promote their independence

or recovery. There were minimal references in care plans to aspirations or enablement to self-manage daily living tasks.
● Care plans were not up to date or reflective of people's current needs and choices. We saw one person's care plan did not reflect changes in their mobility, which had led to significant changes in their quality of life, access around the home and to their community. The change in their needs had not been assessed or responded to in their plans.
● People had not directly contributed to their care plans or reviews. We spoke with one person about their care plan content and they were upset about some information being there which they were not aware of.
● People's care plans did not always recognise their physical health needs alongside their mental health needs. One person's diabetes risks, needs and monitoring was not evident in their care plan. There were no robust monitoring actions regarding their weight, skin health or nail care.
● Where care plans made reference to making decisions for them, in people's best interests, there were no corresponding mental capacity assessments or records to show how people's views about risks had been considered.
● People were asked to contribute to decisions about meals and drinks available. However, we found that where people had diabetes there was little recorded about suitable meal plans, food to avoid, and no analysis of dietary intake to monitor health risks.
● Where people's weight could impact their health, there was no monitoring of this and no guidance to staff about when to seek medical advice and guidance.

Care and treatment was not always person centred. This placed people at risk of receiving care and support which did not meet their needs. This was a continued breach of regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We raised these concerns to senior management to review. They put in place plans and actions to review and update people's care plans with them.

Adapting service, design, decoration to meet people's needs
● When people's mobility changed, adaptations and adjustments were not put in place to ensure they could assess the home's facilities. For example, one person's mobility had decreased significantly, and they could not get to the garden or communal living room.
● Some aspects of the building were homely. The lounge area and dining room had been tidied to provide a clearer space for people to sit. There were posters, art and crafts made by people who lived at the home displayed around communal areas. There was a garden which people told us they really liked, and we saw people using.

Ensuring consent to care and treatment in line with law and guidance
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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● At the time of inspection there were no applications made by the service for the local authority to assess and authorise a deprivation of liberty under DoLS.
● One person's care plan described them as being confined to their room and that decisions had sometimes been made in their best interest. However, there were no mental capacity assessments or risk assessments to ensure the person's rights, views and wishes had been fully considered.

The provider responded to our concerns by reviewing the person's care plan and assessments.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the provider had failed to ensure systems and processes operated effectively to maintain governance of the service and compliance with their responsibilities. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Provider audits and actions for improvements had not been acted on. The provider had carried out a range of environmental and service provision audits since our last inspection, identifying concerns and actions. These concerns remained unactioned at the time of inspection.
● Care plans signed off by the registered manager did not reflect current risks, needs or plans to mitigate risks. There were errors and omissions from care plans which meant staff were not supporting people with accurate information about their needs and risks.
● Care plan records were not kept securely. During our visit we found care plans were kept on a open shelf in an unlocked office which people accessed regularly throughout the day. Care plans contained personal and sensitive information which the registered manager had not ensured were stored securely and only accessed by those authorised to do so.
● Staff recruitment records were not kept securely onsite and so were not accessible at the time of the first inspection day. There were no back-up systems for records to be accessed by delegated staff in the manager's absence. This meant senior managers did not have ready access to key staff records.
● The registered manager had not provided a statutory notification to CQC regarding a serious injury sustained by a person living at the service. This is a regulatory requirement of the registered manager and provider. We found no record of the accident in the incident and accident log and no analysis of the incident.

The provider had not ensured systems and processes operated effectively to maintain governance of the service and compliance with their responsibilities. This was a continued breach of regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us they would investigate the concerns found with the registered manager.

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

● People who lived at the service had been invited to give feedback and share their experiences. This information had been collated and an action plan drawn up, although timeframes for change and improvement had not been set.

● There were no records of feedback surveys, comments or complaints from staff, people's family, friends or representatives or other professionals. There were no scheduled plans for these to take place.

● We saw that the service had worked with external professionals, such as a person's Social Worker. However, the person's records and care plans did not reflect the move-on plans which had been discussed and agreed. Key information from the Social Worker, such as mental capacity assessment outcomes had not been recorded or taken account of in their care plan.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Staff and senior managers understood their responsibility relating to Duty of Candour. We spoke with senior managers who ensured relatives and representatives were kept up to date if things went wrong.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and treatment was not always person centred. This placed people at risk of receiving care and support which did not meet their needs. This was a breach of regulation 9 (1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Imposed conditions on the providers registration which will be reviewed regularly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that people were protected from the risk of avoidable harm. The provider had failed to ensure the proper and safe management of medicines and the control and prevention of infections. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Imposed conditions on the providers registration which will be reviewed regularly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure the premises was properly maintained, standards of hygiene upheld and health and safety risk assessments acted on. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Imposed conditions on the providers registration which will be reviewed regularly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes operated effectively to maintain governance of the service and compliance with their responsibilities. This was a breach of regulation 17(1) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Imposed conditions on the providers registration which will be reviewed regularly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure safe recruitment processes were operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Imposed conditions on the providers registration which will be reviewed regularly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of suitably trained staff who were provided with support and to carry out their role. This placed people at risk of harm. This was a breach of regulation 18(1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Imposed conditions on the providers registration which will be reviewed regularly.