RCH Care Homes Limited

Park View Care Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Park View Care Centre is a residential care and nursing home for people living with dementia and older people. The care home accommodates up to 88 people. At the time of inspection there were 82 people living at the home. There are two units which accommodate people with nursing needs upstairs and there are two units which accommodate people living with dementia downstairs. The upper floors are accessible via a lift. Each unit has their own communal dining and lounge facilities.

People's experience of using this service and what we found
There was a lack of guidance for staff to follow to care for people effectively and staff did not know how to meet the needs of some people. People were not supported positively with behaviour that challenged. Risk management was poor which meant people were at risk of avoidable harm, for example from falls or constipation.

The provider had failed to ensure people were always supported in the least restrictive way in line with current law. Some staff were not aware of when they needed to safeguard people from abuse. We found two people at risk of harm which the registered manager alerted the local safeguarding team about following our inspection.

There was not always enough staff available to meet people's needs. People told us they had to wait a long time when they rang the call bell. Staff had received training for their role, but the provider had failed to ensure staff were knowledgeable on safeguarding people from abuse. People told us there were some language barriers with staff who did not speak good enough English.

Medicines were managed safely except for 'as required' medicines. There was a lack of guidance for staff when people needed these medicines and how to monitor their effectiveness. There was a lack of learning from accidents and incidents. It was not always clear what action had been taken and lessons had not always been learnt to prevent a reoccurrence.

Infection prevention and control was not always managed as we observed staff moved between units on the ground floor without changing their Personal Protective Equipment (PPE). This increased the risk of the spread of infection. Quality systems were not always effective and had either not identified the issues we found or where they had identified issues, they had not always been actioned.

The provider had not always acted within the law and best practice guidance. Some people's care plans did not recognise when they were being restricted. People's mental capacity assessments were not completed for specific decisions around their care. The registered manager did not promote positive behaviour support. People did not always receive person centred care as their needs were not always fully planned for and staff did not always have the guidance they needed to provide care to people.

People were not always engaged in their care and the service as there was a lack of guidance for staff how they could communicate with some people. People's relatives told us they were happy with the communication they had with the staff and were kept updated on their loved one's care.

The registered manager had not understood their responsibilities on the duty of candour. They had informed relatives of incidents or accidents but they had failed to recognise neglect of their duty of care and breaches of people's human rights and therefore had failed to report and act on these.

Some staff knew people well and we observed some positive, caring interactions with people. Staff were positive about the support they received from the registered manager. The provider had notified CQC about events as required. The provider had displayed a copy of their ratings in easy view for people and visitors at the service.

People told us when they raised complaints these were resolved quickly. The provider had sought and acted on feedback to identify areas for improvement.

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

Rating at last inspection
The last rating for this service was Good (published 7 October 2020).

Why we inspected
This inspection was prompted by our data insight that assesses potential risks at services, concerns in relation to aspects of care provision and previous ratings. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. This enabled us to look at the concerns raised and review the previous ratings.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Park View Care Centre 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 will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection we have identified breaches in relation to managing risks to people, ensuring people are not unlawfully restricted; ensuring staff are knowledgeable about safeguarding people and ensuring there are enough staff available to keep people safe and meet their needs. We have also identified breaches in relation to the providers failure to assess, monitor and improve the quality and safety of the service; and maintaining accurate and up to date care records.

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

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 is therefore 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Park View Care Centre

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.

We are improving how we hear people's experience and views on services, when they have limited verbal communication. We have trained some CQC team members to use a symbol-based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with two people to tell us their experience.

Inspection team
This inspection was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Park View Care Centre 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.

The service had a manager registered with the Care Quality Commission. 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and four relatives about their experience of the care provided. We spoke with 12 members of staff including the registered manager, deputy manager, dementia unit manager, customer relations manager, head of HR, one nurse, and six care workers.

We reviewed a range of records. This included six people's care records and associated risk assessments. We looked at three staff files in relation to recruitment records. A variety of records relating to the management of the service, including audits and meeting minutes were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke with one professional who regularly visited the service.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- There was a lack of recognition of the use of restrictive practices in the service. Seclusion and chemical restraint were used to manage people's behaviour without assessment as to whether the measures used were the least restrictive and used for the shortest time possible. For example, staff told us one person could be secluded in their room up to four hours to calm down and chemically restrained from the use of covert medication. This is not in line with best practice guidance and the law and is without proper authorisation.
- We were not assured that staff would recognise and report all incidents of alleged abuse. Despite the provider evidencing good compliance with training, not all staff had a good understanding of the principles of safeguarding and the systems to keep people safe from abuse. Four staff we spoke with struggled to demonstrate their knowledge of this.
- The registered manager had submitted safeguarding alerts to the local authority and the Care Quality Commission (CQC). However, there were two people we found to be at risk of harm from repeated falls and self-harm. No action had been taken to raise these repeated concerns as a failure in their duty of care with the local safeguarding authority or CQC. We asked the registered manager to report these and they did so immediately following our inspection.

The provider had failed to follow current legislation and guidance in lawful seclusion and restraint. The provider had failed to ensure systems and processes were operated effectively to prevent abuse of people. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- At our last inspection we identified people may benefit from positive behaviour support plans to offer more details to staff of the approach to take. We also suggested using more formal debriefing records with staff following incidents of behaviour that challenged. These may help to further identify lessons that could be learned from incidents. At this inspection we found people were not supported positively with behaviour that challenged. There was also a failure to recognise the impact of the environment on people's behaviours. For example, one staff said, "Some people are aggressive all the time and shouting because of the noise."
- There was no guidance for staff how to care for one person who consistently self-harmed. Their care records identified they were often anxious but there was a lack of functional assessments or strategic measures for staff to follow to care for this person effectively. Staff we spoke with about this person did not know how to meet their needs to reduce the risk of self-harm and meet their emotional needs. As a result, they had continued to self-harm. The registered manager implemented a care plan for this immediately

during our inspection.
● Risk management was poor which meant people were at risk of avoidable harm. One person had been to hospital with head injuries from falls on three occasions. This person had fallen 30 times in seven months and five of these falls had not been recorded on the accident log. There was a lack of effective and up to date mitigation measures recorded on their risk assessment and falls assessment. A sensor mat was used at night to monitor if the person was out of bed, this was known to be ineffective as the person was known to step over this, yet this had not been reassessed. Their care plan mentioned the use of inappropriate footwear, but this had not been included in their falls risk assessment. There was no mitigation of specific risks around their footwear and previous factures.
● Another person was at risk of harm as the provider had failed to mitigate the risk of constipation. Their care plan did not provide the guidance staff needed, for example what causes their constipation and what could help manage this, such as movement, diet, hydration and foods to encourage or avoid. There was no monitoring of the persons bowel movements to identify if they may be constipated. There was no guidance when staff should take action if the person became constipated and how to manage the use of medicines for this.

The provider had failed to do all that is reasonably practicable to assess and mitigate risks to the health and safety of people. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some environmental risks were managed. For example, risks to people around fire safety were safely mitigated with all the expected safety checks and assessments completed. People had personal emergency evacuation plans in place, these were to ensure people could leave the building safely in the event of an emergency.

Staffing and recruitment
● The provider had not deployed enough staff to meet people's needs. The registered manager used a well-known dependency tool to identify people's level of need and determine staffing levels needed in the service. However, this was not completed accurately, for example, one person at high risk of falls and therefore high dependency had been scored as medium instead of high between January and May 2021. The additional score for people with dementia had not been completed and their risk assessment for falls described their dependency as medium. Their needs had been translated to the staffing levels as low instead of high.
● People told us staff can take a long time to respond when they ring the call bell. Comments included, "Sometimes they are a bit tight for staff in the morning when everyone needs a wash"; "We are short staffed at weekends, it's a job to find staff at weekends so I am told." We spoke with the registered manager about this who confirmed there was no system to record call bell response times.
● Staff told us there was not enough staff. One staff said, "To be honest we are most of the time short staffed…If staff call sick, we are short…With a little bit more staff we can care more I think and give more care to residents up and downstairs." Another said, "Pretty often we are short staffed, in morning there isn't time to wash and dress everyone…managers try to find someone but not always covered. If you are in the middle of something, you can't respond to the call bell, it's a big unit, you run back and forth."
● All staff had completed a full induction and training programme to support them in their role and to meet people's individual needs. For example, training around diabetes and dementia. Nursing staff had completed additional training with competency checks for specific procedures. However not all staff could demonstrate their knowledge was sufficient. The registered manager told us staff competencies were checked, but we identified shortfalls in staff knowledge. For example, around safeguarding people. This meant there was a risk staff would not identify abuse and act to safeguard people appropriately.

● Not all staff were skilled enough in the English language. Feedback from people identified there were communication barriers between some staff and people. Some people felt staff could not understand them. One person said, "It is lovely here, but it is inconsistent as so many of them cannot speak English, I really struggle with the language barrier." One relative told us they had complained to the registered manager about the language barrier between staff and was told, 'It is impossible to get English staff.' The registered manager was aware of these concerns and told us they were strict on employee interviews to ensure staff could speak adequate English. However, this had clearly not been effective. We observed people struggled to communicate with and understand care staff, particularly on the dementia unit.

The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely. All the required pre employment checks were completed. For example, gaps in employment, references and Disclosure and Barring Service (DBS) background checks for all staff. These checks help employers to make safer recruitment decisions.

Preventing and controlling infection
● We were not assured that the provider was using PPE effectively and safely. We observed staff moved between units on the ground floor without changing their PPE. The registered manager confirmed they were supposed to do so.

The provider had failed to do all that is reasonably practicable to manage the prevention and control of infection. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Using medicines safely
● There was a lack of protocols in place to provide guidance for staff when people need their 'as required' medicines and how to monitor their effectiveness. This included medicines to help people with agitation and constipation. This is not in line with the National Institute for Health and Care Excellence (NICE) best practice guidelines for medicines in care homes. NICE is the independent organisation responsible for driving improvement and excellence in the health and social care system. We spoke with the registered manager about this who immediately implemented a protocol for one person's 'as required' medicines for constipation.

The provider had failed to ensure the proper and safe management of medicines. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were effective systems in place to ensure other medicines were managed and people received their other prescribed medicines safely. People we spoke with told us they received their medicines on time and could tell us what their medicines were for.

Learning lessons when things go wrong

● The registered manager and provider had a system for reviewing incidents and accidents, but this was not effective. It was not clear what action had been taken as a result of each accident or incident and lessons had not always been learnt to prevent a reoccurrence. There was a lack of learning to identify trends and mitigate risks, for example the date and time of falls were recorded but these had not been analysed to determine if there were more falls at certain times of the day or night and/or when there were less staff on site.

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 Good. At this inspection this key question has now deteriorated to 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.

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

- The registered manager did not promote positive behaviour support. For example, they described one person's behaviour as, 'Attention seeking' and another was referred to as, 'They are so complex with falls and behaviour'. This demonstrates a lack of understanding of positive behaviour support and the need to understand the function of the persons behaviour in order to meet their needs. This also shows a lack of dignity and failure to treat people with care and compassion.
- People did not always receive person centred care as their needs were not always fully planned for. People's care records were not always person-centred as they were not always accurate and up to date. Some staff described the care they gave people which was not recorded in their care plans. This meant there was a risk that new or agency staff would not have the guidance they needed to meet people's needs.
- Some people did not have care plans to meet their needs, for example one person with Parkinson's did not have a care plan for this. This meant staff did not have the guidance of what a good day or bad day may be like for this person and how to support them at either extreme. The lack of supporting people effectively with symptoms of their dementia had resulted in incidents of behaviour that challenged and the use of unlawful restrictive practice.
- Some care plans were handwritten and illegible, we asked staff to read these who confirmed they couldn't read the plans.
- Staff were given cards when they started on the company's values. Some staff we spoke with could not describe the company's values to us, although they were displayed in the reception of the home. Some staff knew people well and we observed some positive, caring interactions with people. For example, we heard staff engage one person well in a conversation and by talking about what was on their mind they were able to distract them in order for them to eat. However, we also observed there was minimal interactions between people and staff on the dementia unit.

The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and maintain accurate and contemporaneous records of people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had not ensured all regulatory requirements were met and had failed to act in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People had been unlawfully restricted. People's care plans did not recognise when they were being restricted and people's mental capacity assessments were not decision specific. There was a risk that people had restrictions placed on them unnecessarily or not in the least restrictive way. One person had a condition on their DoLS for an overview of their 'incidents of behaviour' to be in place and this had not been met.
● Quality checks and audits were in place and completed by the registered manager and the providers senior team. However, these were not effective. For example, managers audits and care plan audits had either not identified the issues we found or where they had identified issues, these had not been translated onto an action plan or appropriate action taken. Following our inspection, the provider has updated their service development plan to include the concerns we raised. However, we highlighted at our last inspection how they could improve their practice around positive behaviour support planning and the provider had not actioned this.
● The provider had failed to identify the lack of staffing. The provider did not have an effective system in place to monitor call bell response times and therefore there was no analysis of this. Call bells were tested during twice daily walk arounds and time taken to respond was noted but not analysed. It was also clear that not all staff were skilled in supporting people living with dementia. Training, supervision, competency checks and 'walk arounds' by the registered manager were not effective in identifying this.
● The registered manager had not understood their responsibilities on the duty of candour. They had informed relatives of incidents or accidents and worked with other healthcare professionals. However they had failed to recognise neglect of their duty of care and breaches of people's human rights and therefore had failed to report and act on these.

The provider had failed to assess, monitor and improve the quality and safety of the service; and mitigate the risks relating to the health, safety and welfare of people. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us the registered manager was approachable, helpful and would listen to any concerns they had. One staff member said, "You could text them (registered manager) at two am in the morning and they would reply." The provider had put systems in place to recognise and reward staff achievements and encourage motivation. For example, 'employee of the month' and providing treats. The registered manager was available to staff and encouraged them to seek any support they needed.

● Registered persons are required to notify the Care Quality Commission (CQC) about events and incidents such as abuse, serious injuries and deaths. The provider had met all these regulatory requirements and notified CQC as required.
● It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. The provider had displayed a copy of their ratings in easy view for people and visitors at the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● One person's communication profile only described one-way communication, how staff could communicate with the person. There was a lack of guidance for staff how this person communicated. Another person's communication care plan failed to describe how they would communicate their needs when they were confused due to living with Parkinson's. Therefore, there was a lack of guidance for staff

how they could engage these people in their support and the service.

The provider had failed to assess, monitor and improve the quality and safety of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● One person had taken on a role of 'head resident' and told us they worked closely with the customer relations manager. They assisted with greeting new arrivals. They were clearly well engaged with the service.
● People's relatives told us they were happy with the communication they had with the registered manager and client relations manager. They told us they were kept updated on their loved one's care and spoke highly of the staff. There had been less face to face engagement with people's families due to Covid-19. The registered manager had therefore planned a 'welcome back' outdoor event, inviting people's family and friends to the home.
● Team meetings were held regularly, and newsletters sent to staff to engage staff in the service. The staff worked in partnership with other health professionals to meet people's needs, for example, dieticians, specialist nurses, GPs and speech and language therapists (SALT). The registered manager had sought advice from the community mental health team with regards to one person self-harm but this had not been translated into guidance for staff to follow.

Continuous learning and improving care
● Learning from accidents and incidents had not been effectively used to improve the quality of care in the home.
● People told us they had raised complaints which had been dealt with effectively. For example, one person told us they had spoken with the registered manager over the volume of music and doors banging. They said the registered manager 'dealt with it right away and staff are more courteous now with the closing of doors.'
● The provider had sought feedback and had completed surveys with people to identify areas for improvement. For example, where people had said the food could be improved, they completed a smaller survey to identify how they can improve the dining experience for people. They had also launched their 'Butler nutrition project' to improve nutrition in the home.