Park View Nursing Home Limited

Park View Nursing Home Limited

Inspection report

Lee Mount Road, Ovenden, Halifax HX3 5BX
Tel: 01422 350088
Website: www.parkviewnursinghome.co.uk

Date of inspection visit: 30 November and 7 December 2015
Date of publication: 01/02/2016

Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection took place on 30 November and 7 December 2015 and was unannounced.

At the last inspection on 13 and 22 April 2015 we found seven breaches in regulations which related to staffing, safe care and treatment, safeguarding, safety of the premises, dignity and respect, person-centred care and good governance. Following the inspection we took enforcement action. The commissioners at the Local Authority and Clinical Commissioning Group (CCG) were made aware of our concerns and placements at the home were suspended.

We carried out this inspection in response to concerns received about the care people received at night and to check if improvements had been made following our inspection in April 2015. The suspension on placements was still in place when we visited.

Park View Nursing Home provides accommodation and nursing care for up to 43 older people. There were 22 people living at the home when we visited. This included 18 people receiving nursing care and four people receiving personal care.

Summary of findings

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

The home had a registered manager who left in May 2015. A new manager was appointed but had not registered with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe from abuse as staff were aware of safeguarding procedures and we saw these were followed when abuse was alleged or suspected. Staffing levels were sufficient to meet people's needs, however we found recruitment processes were not always being followed to ensure staff's suitability. The training matrix was incomplete which meant we could not be assured staff had received the training they needed. Although some supervisions and appraisals had been completed the manager acknowledged these were not up to date.

The management of medicines had not improved and unsafe systems meant people were not always receiving their medicines as prescribed.

People enjoyed the food however we found people's weight and nutritional needs were not being monitored effectively placing people at risk of not receiving sufficient amounts to eat and drink. People had access to healthcare services however, a lack of communication meant advice was sometimes not followed through by staff.

Staff lacked knowledge and understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which meant assessments and best interest decisions were not considered when people lacked capacity to make a decision.

Improvements had been made to the environment and we found the home was generally clean and well maintained.

Staff engagement with people had improved and we saw staff were kind and caring in their interactions with people. Staff showed respect for people's privacy and dignity and supported them to maintain their independence. An activity co-ordinator had recently started employment and had developed a good rapport with people.

An electronic care record system had been implemented since the last inspection, however we found information recorded was sometimes contradictory and did not reflect people's current needs. This was concerning as the home relied upon agency nurses to lead the care team and ensure care was delivered to meet people's needs and a lack of accurate care records placed people at risk of receiving inappropriate or unsafe care.

The home had a complaints procedure but this was not made available to people who used the service. We saw complaints were not always dealt with in accordance with the home's procedures.

Although the manager has been committed to making improvements, progress has been limited due in part to a lack of permanent nursing staff to support them in their role. Quality assurance systems have failed to identify or address issues for example with regards to medication, consent, complaints, nutrition, care records and records relating to the management of the service such as training and recruitment.

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this time frame so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there

Summary of findings

is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Medicines management was not safe, which meant people did not always receive their medicines as prescribed.

Recruitment processes were not followed consistently which placed people at risk as staff's suitability was not always checked thoroughly.

Staffing levels were sufficient to meet people's needs and improvements had been made to the environment. Staff had a good understanding of safeguarding procedures and these were being followed.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received the support and training they required to fulfil their roles.

Mental capacity assessments and best interest decisions were not recorded and staff lacked understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's weight and nutritional needs were not monitored effectively and a lack of communication between staff meant healthcare advice was not always followed.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate with people and engaged with them.

People's privacy and dignity was respected. Staff supported people to maintain their independence.

Is the service responsive?

Inadequate

The service was not responsive.

Care was not planned or delivered to meet people's individual needs.

Some activities were taking place and a programme was being planned by the newly appointed activity co-ordinator.

The complaints procedure was not available to people who used the service and complaints were not always dealt with in accordance with the home's policy.

Is the service well-led?

Inadequate

The service was not well led.

Summary of findings

There was no registered manager. Although the manager had worked extremely hard to make improvements, progress had been limited due to the lack of permanent nurses and we found continued breaches in regulation.

Quality assurance systems were not robust in identifying and rectifying issues for example with regards to medication, consent, complaints, nutrition, care records and records relating to the management of the service such as training and recruitment.

Park View Nursing Home Limited

Detailed findings

Background to this inspection

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

This inspection took place on 30 November and 2 December 2015 and was unannounced. On 30 November 2015 two inspectors visited the home in the evening due to concerns we had received about the care people received at night. On 2 December 2015 we visited during the day and there were three inspectors and a pharmacist inspector.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted commissioners from the local authority, Clinical Commissioning Group (CCG) and the local authority safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We did not send a PIR to the provider before this inspection.

We spoke with five people who were living in the home, five care staff, two nurses, the activity co-ordinator, a kitchen assistant, the cook, the manager and the provider.

We looked at nine people's care records three staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Requires improvement

Is the service safe?

Our findings

At our previous inspections in November 2014 and April 2015 we found a regulatory breach in relation to medicines as appropriate arrangements for the safe handling of medicines were still not in place. At this inspection we found this was still the case.

We spoke to the manager and nurse responsible for the administration of medication and looked at medication stocks and records for 13 people.

Medicines were stored securely, but not always at the correct temperature. The minimum and maximum temperatures of the medication fridge were recorded daily and showed that the temperature had been over double the maximum recommended for safe medicines storage between October and December 2015. There was no evidence of any action having been taken to address this concern. Medicines may spoil or become unfit for use if they are not kept at the correct temperature. Some medicines, such as insulin, only have a limited lifespan once opened, but opening dates had not been recorded. This meant that we were unable to tell whether they were fit for use. Failing to ensure the safe storage of medicines places people at unnecessary risk of harm.

Where possible, the pharmacist supplied medication in a Monitored Dosage System and these medicines could be accounted for clearly. However, a check of medicines supplied in bottles and boxes showed that some medicines had been signed for, but not actually given. Supplies of medicines carried forward from the previous month had not been recorded and this made it difficult or impossible to determine whether these medicines had been given correctly. There were missing entries and signatures on records and it was unclear if medicines had been given or omitted at those times. Where medicines were prescribed at a variable dose, the actual dose administered had not always been recorded. Care workers applied the majority of creams and other topical medicines however there was no still no system in place for nurses to check that these products had been used correctly. Records for the application and use of external preparations were incomplete and unclear meaning that we were unable to tell whether or not these products had been used as prescribed.

People were not always given their medicines as prescribed. Records for one person with an infection showed that they had been given their medicine four times a day for over 10 days, but when we looked at the stock remaining we found they had only received approximately five doses. This meant that the infection had not been treated effectively, placing this person's health and wellbeing at risk of harm. Another person had been prescribed a gel for a mouth problem, but we saw that the tube was still sealed and had not been used. We also saw that three different people had not had any of their painkillers available as stock had run out and not been reordered in good time. The health and wellbeing of people was at serious risk of harm if they were not given their medicines as prescribed.

Many people were prescribed medicines that needed to be taken only when required e.g. painkillers. We found that there was still not enough information available to enable nurses to give these medicines safely, consistently and with regard to people's individual needs and preferences. Having this information available is particularly important for agency nurses who may not be familiar with people living in the home. Records of changes to people's medicines were not recorded fully and consistently. This meant that it was not always possible to see whether some items, for example nutritional supplements, had been discontinued or had run out.

The manager told us about two incidents where people had been given the wrong dose of their medicines. We saw that these incidents had been reported appropriately, however in one case action had not been taken to prevent the error being repeated. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We looked at three staff recruitment files. We spoke with one newly recruited care worker who said they had completed an application form, attended an interview and been required to provide two references and have a criminal record check before they started work. This was confirmed by the information recorded in their recruitment file. We saw an entry in the file saying their references had been verified. The administrator explained on receipt of the references they had phoned the named referees to confirm the references. However, we found this had not been done

Is the service safe?

in the two other files we looked and when we asked the provider they said it was a new process they had implemented following a compliance visit from the Clinical Commissioning Group (CCG).

In the second staff file there was no evidence a check had been carried out to confirm the applicant's registration with the Nursing and Midwifery Council (NMC). We asked the manager about this and they confirmed there was no evidence to show this check had been completed. In the same applicant's file we found one of their references was from a work colleague and the other was from a former employer's organisation. However, it wasn't clear what the referee's role was within that organisation or how long they had known the applicant.

In the third staff file we saw one reference from a previous employer confirmed the dates of employment but declined, due to company policy, to provide any more information. The second reference, from another former employer, stated the applicant had left without notice. There was no evidence to show this had been followed up with the referee or the applicant to explore the reasons for this. The provider's recruitment and selection policy dated July 2015 stated they would verify the reasons job applicants had left their previous employment. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We found staffing levels had improved. Staff we spoke with told us there were enough staff on duty to meet people's needs and team work was very good. We saw care staff worked well together and when people required assistance with personal care this was done in a timely way. Call bells were answered promptly and staff did not look rushed and had time to sit with people. For example, in the afternoon we observed staff sitting in one of the lounges with people while they recorded the care they had provided on the computer tablets. One staff member said it would be nice to have more time to spend sitting and talking to people but overall they felt there were enough staff available.

No concerns were raised about the numbers of staff on duty however staff told us at night there was often only one permanent staff member working with two agency staff. Although the provider and manager tried to ensure the same agency staff attended to provide consistency, staff told us at weekends there were often agency staff who had not worked at the home before. They told us this placed pressure on the permanent staff member who had to support both the agency nurse and agency care staff member. The provider told us they recognised more permanent staff were required at night and said they had recruited care staff for night duty who were due to start when recruitment checks had been completed.

At our previous inspections in November 2014 and April 2015 we found a regulatory breach in relation to safeguarding. At this inspection we found improvements had been made.

The training matrix showed 27 staff had completed safeguarding training since the last inspection. Care staff we spoke with were able to explain what abuse was and were aware of how to report any concerns internally and/or to external agencies such as the Local Authority or the Care Quality Commission if necessary. They said they believed people who lived at the home were safe and well cared for. We saw evidence which showed safeguarding referrals had been made to the Local Authority appropriately and notified the Care Quality Commission. On the second day of our inspection a safeguarding concern was raised by a person who used the service and we saw staff responded promptly and took action to safeguard the person and made a referral to the Local Authority safeguarding team.

Overall we found the home was generally clean and well maintained. On the second day we looked around some parts of the building. We noted an odour in one bedroom, which we reported to the provider and manager who said they would deal with it straight away. Two maintenance staff were working in the home when we visited on the second day and we saw them checking wheelchairs and carrying out other routine checks.

Information we received from the Infection Prevention and Control (IPC) Team prior to the inspection showed they had visited in November 2015 to follow up on the action plan the home had put in place following an IPC audit in April 2015. They noted progress had been made, although some areas were still to be addressed. When we visited in the evening on 30 November 2015 we found soiled laundry and a soiled incontinence pad in one person's en-suite. Both were in separate bags but the bags had not been tied up and the smell in this room was very offensive. We saw a care worker go into this room but they did not remove either of the bags. The nurse on duty told us this person had diarrhoea and gloves and aprons were in use as an infection prevention measure, however, we saw on the table outside of the bedroom there were only aprons

Requires improvement

Is the service safe?

available. We checked this person's bedroom again two hours later and both bags were still in the en-suite and although they had been tied up the offensive odour remained.

Inadequate

Is the service effective?

Our findings

At our previous inspections in November 2014 and April 2015 we found a regulatory breach in relation to staff training. We found staff had not received the training they required for their roles and the training matrix was not fully completed. At this inspection although some training had been delivered the same issues remained.

We looked at the training matrix which was incomplete and showed significant gaps where there were no training dates for staff. Although we saw some staff had completed training this year in topics such as safeguarding, control of substances hazardous to health (COSHH), fire training, health and safety, infection control and basic food hygiene, the attendance numbers were low. For example, only three staff were listed as having completed basic food hygiene. From the evidence provided by the manager we were not able to establish that staff had received the training they required to equip them with the knowledge and skills for their roles. Information we received from the Clinical Commissioning Group (CCG) showed they had identified similar issues with regard to the recording of training at a visit in September 2015 and had discussed these with the manager. Our inspection showed improvements had not been made.

The manager told us training on safe working practices such as fire safety, safeguarding and infection control was delivered in house. The manager led work groups where staff watched a DVD, had a discussion and completed questionnaires. The manager confirmed they did not have any training qualifications and said the questionnaires were not sent to any external organisation to be checked. They added in the New Year they hoped to engage the services of an external agency to check the questionnaires. The staff we spoke with confirmed most of the training they received was delivered in house.

The provider told us the home had a trained moving and handling co-ordinator. However, when we checked this staff member's training certificate they had completed the training in October 2012 and the manager confirmed it had expired in October 2015. The manager said they intended to enrol the person on another course. In the meantime they said they had engaged an external training organisation to provide training on safe moving and handling. Staff confirmed they had received practical training on moving and handling which included the use of hoists.

One of the care workers we spoke with said they had completed an induction when they started work at the home and this included shadowing other staff until they got to know about people's care needs. However, we were unable to find any record of their induction. The manager said they would send it to us but this had not been received.

We saw completed induction checklists for two other staff who had recently been employed which included an orientation to the home, health and safety, fire safety and other topics such as infection control and safeguarding. The manager told us all new care workers were undertaking the Care Certificate training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The manager said in the longer term they planned for all their existing care workers to complete the Care Certificate training so that everyone was working to the same set of standards.

The manager had a plan for staff supervision and appraisals, they said supervisions should take place every three months and appraisals once a year. However, they said the delivery of supervision and appraisals had fallen behind schedule and this was confirmed by the planner we reviewed which showed 14 out of 47 staff listed had received one supervision since April 2015 and one staff member had received two supervisions. Fourteen staff had received an appraisal. The care workers we spoke with were not really clear about supervision and appraisal. One care worker told us they had attended one supervision meeting earlier this year, however, when we then asked them about appraisals they said it might have been an appraisal. Another care worker said they had supervisions every month or two and had an appraisal every two or three months. We found staff had not received the appropriate training, supervision and appraisal necessary to enable them to carry out their duties. This was a breach of the Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. 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 manager told us they had DVDs which they used to provide training to staff about the MCA and DoLS. However, the care staff we spoke with had no working knowledge of this legislation. One care worker said they had heard about it but could not remember what it was about and another said they thought it was about how to communicate with people living with dementia.

The provider told us one person had a DoLS authorisation in place, the nurse in charge told us three people had DoLS authorisations. However, we established no one had a DoLS authorisation in place. The manager told us an application had been made but they had not been informed of the outcome. The person's care records confirmed an application had been submitted. An assessment of the person's mental capacity had been carried out to support the application. However, the assessment lacked detail and only stated the person had dementia which was impeding their understanding of the need to stay at the home. There was no evidence an assessment of capacity had been carried out in relation to other aspects of the person's care and treatment and there were no recorded best interest decisions. For example, the person's care records contained repeated references to them refusing medication but there was no assessment of their capacity to understand the implications of this decision. Similarly, there was no evidence of best interest decision making about their refusal to take medication, the records just said their GP was aware of this. Another person's care records showed they had a diagnosis of dementia and their care plan showed they were unable to use the call bell system and sensor mats were used in their chair and beside their bed so an alarm was triggered to alert staff if they got up. There was no evidence of an assessment of their capacity to consent to this restriction or any record of a best interest decision.

We observed staff asked people for their agreement before providing care and support, for example asking people if they wanted protective covers over their clothing at meal but did not see anything about consent to care and treatment in people's care records. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw from the menus there was a choice available for every meal. Pictorial menus were on display in the dining room to help people make an informed decision about what they would like to eat. We spoke with the chef who knew about people's individual likes and dislikes and explained if people did not like anything on the menu they would make them something else.

One person told us they had enjoyed their breakfast which had consisted of, "Two eggs and toast" and another person said they had enjoyed their favourite cereal, Rice Krispies. Mid-morning and mid-afternoon hot drinks and biscuits were served and fresh fruit was also available in the afternoon. We saw people had cold drinks available throughout our visit. At lunchtime we saw the tables were set with tablecloths, serviettes, placemats, cutlery and condiments. The meal looked appetising and gravy was served in separate jugs so people could help themselves. Staff sat with people who required assistance and the mealtime was a sociable and pleasant occasion.

We noted most of the main meals were served on small plates. We asked the chef and kitchen assistant about this and they told us this was because some people only wanted smaller portions. However, we saw some of the small plates had a lot of food on them which would have been better presented on a large plate. We asked the chef how they fortified the diets for people who were losing weight. They told us they added coronation milk or cream to milk puddings and used full fat milk for drinks and custard. They also said when they had butter they added this to the mashed potato. There was no information from the care planning process to assist the chef in providing suitable fortified meals.

We found people's weight and nutritional needs were not monitored effectively. For example, one person's nutrition

care plan had last been reviewed on 22 October 2015. The care plan stated the person enjoyed a varied diet and their appetite could vary. It stated staff should be aware of the person's likes and dislikes and offer a choice of food. There was no other information to guide staff on how best to support the person with their dietary needs. In the care plan about supporting the person to meet their continence needs there was an action which stated staff should make sure they had an 'adequate' fluid intake. There was nothing to say what amount of fluid staff should be aiming to provide. On the person's medication chart we saw they had been prescribed nutritional supplements but none had been recorded as given throughout November 2015. There was no reference to nutritional supplements in the person's care plan. The records showed a discussion with the district nurse in September 2015 who had advised the nutritional supplements were no longer needed because the person's weight was stable. However, records showed this person had lost just under 4kgs between 17 October 2015 and 1 November 2015 and there was no evidence to show the person's dietary needs had been reviewed. There was no target weight in the person's care plan to guide staff on what the person's weight should be. This meant the person was at risk of not receiving the right support to meet their nutritional needs.

In another person's records their dietary needs care plan stated they had a poor appetite, had lost interest in food and had some difficulty eating. The care plan did not state a target weight and the records showed the person's weight was fluctuating. They had gained 6.5kg between 16 July 2015 and 22 September 2015 and then lost almost 3kg by 6 December 2015. The actions in the care plan stated staff should encourage eating and drinking and offer a choice of menu. It did not have any information about the person's likes or dislikes and provided no guidance to staff on how best to support the person to eat. The care plan did not have any target weight and made no reference to fluid intake. The care plan for elimination stated the person should have 1.5 litres of fluid every day. The fluid intake records showed this was consistently not being achieved, for example between 16 November 2015 and 6 December 2015 there were only two days, out of 19, when the person's fluid intake was over 1500mls, the highest being 1650mls. On six days the person's fluid intake was less than 1000mls and on one day, 5 December 2015, there were no fluids recorded. We looked at the fluid intake records back to July 2015 and found this pattern was repeated. There was no evidence this was being monitored by the nursing staff or that action was taken in response to low fluid intake. This meant the person was at risk of not receiving the right care and support to meet their nutritional needs. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information in care records showed people had access to external health care professionals, such as district nurses, Quest matron, advanced nurse practitioners, GPs and saw one person had been visited by the dentist. However, this information was hard to find in the care records as it was in with the daily care records or in the medical notes section which was also used by nursing staff to record daily care. We found the district nurses were still involved in the care of people assessed as needing nursing care. When people are assessed for nursing care it is normally the responsibility of the nursing home to meet their nursing care needs. We asked the manager about this and they said the district nurses were helping out because the home did not have enough permanent nursing staff.

We saw one person had been to an out patient's appointment in November 2015 and following the visit one of the nurses had recorded the doctor had said they needed to be 'on a water tablet.' The nurse had then written the GP will deal with it. There was no evidence from the records that this had been passed on to the GP. We looked at the person's medication records and found they were not taking any 'water tablets.' This meant there was no evidence of instructions from the out patient's appointment being followed or of any consultation with the GP about additional medication. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

At our previous inspections in November 2014 and April 2015 we found a regulatory breach in relation to dignity and respect. We observed practices which showed a lack of respect for

people and undermined their dignity. At this inspection we found improvements had been made.

People we spoke with told us they were satisfied with the care they received and praised the staff. One person said, “Staff here are very good.” Another person said, “I like it here. Staff are good and they know what they’re doing.”

We saw all of the staff treated people with dignity and respect. We saw staff were gentle and patient in their approach. When staff spoke with people they called them by name and either sat down next to them or knelt down so they were on the same level. We saw staff explained what they were doing when supporting people, for example when assisting someone to move with a hoist. Staff were discreet when asking people about their personal care needs and ensured any personal care was carried out in private. People looked well cared for and well groomed.

There was a warm and friendly atmosphere in the home and we observed people were comfortable with staff. We saw staff engaged with people and knew about their preferred routines and how they liked to spend their time. We saw people's bedrooms were clean and tidy and personal effects such as photographs were on display and had been looked after. This showed staff respected people's belongings.

We saw staff offered people choices, supported them in making decisions and respected their responses. For example, during the morning we observed one staff member going around asking people what they wanted for lunch and tea. They sat down with two people in the dining room and started a conversation about the food, all three had a good chat and a laugh and while this was going on the staff member was gently supporting people to choose their preferred meal. One person said they didn’t know if they liked, “pate” which was one of the options at tea time. The staff member said they would ask the cook to put some on a piece of toast on the side so that they could try it. They then brought the cook into the conversation and everyone spent a few minutes discussing different types of pate.

Two of the staff we spoke with told us one of the positive features about life for people at Park View Nursing Home was they could do what they wanted. For example, if people wanted to stay in bed they could and could get up and go to bed as they wished. People told us staff respected their routines. On the day of the inspection one person told us they had got up at 6.10am. They said they liked to get up early and staff helped them to do this. Other people who chose to get up later were able to do so and we saw people getting up and having breakfast throughout the morning.

Staff we spoke with were able to tell us about people’s individual needs and preferences and understood the importance of supporting people to keep their independence. For example, they told us one person needed support to wash and dress but was able to wash the top half of their body and brush their teeth with prompts from staff.

Staff told us they were allocated their area of work each day which meant they got to know about everyone who lived at the home and their individual needs and preferences. They said they did not have a key worker system, where staff take on extra responsibilities for small groups of people.

Inadequate

Is the service responsive?

Our findings

At our previous inspections in November 2014 and April 2015 we found a regulatory breach in relation to person-centred care. We found care records were incomplete and did not contain sufficient detail to guide staff in how to meet people's individual needs. At this inspection although a new electronic care planning system had been implemented we found similar issues.

We saw two people had been assessed as being at high risk of developing pressure ulcers. Both people used specialist air flow mattresses to reduce this risk, however, there were no details in the care plans about what settings the mattresses needed to be on. For example, we saw one person's mattress had been set to 'firm.' We asked the manager if this was the correct setting in relation to this person's weight and they told us it was not. This meant the therapeutic value of the mattress would have been reduced and could have caused damage rather than preventing it.

During our evening visit we asked one of the care staff what continence products one person used and they told us they used 'yellow pads' and these should be in the wardrobe. We saw there were no continence pads in the bedroom or in the wardrobe. We looked at the care plan and this stated 'small white pads' were used during the day and at night. We could not find any continence assessment for this person which identified the number and type of pad to be used. When we returned on the 7 December 2015 we saw this person's care plan had been updated with the colour and number of pads to be used during the day and night. However, it still stated on the continence care plan 'small white pads' to be used during the day and night. We spoke to the manager about this and they told us this had been an oversight and the reference to small white pads should have been removed. Without continence assessments being in place it was unclear how staff decided which pads to use. There was a range of products available but each individual needed to have a clear plan to make sure their continence needs were being met.

We saw from one person's daily records their care needs had changed significantly over recent weeks, however, their care plan had not been updated to reflect this. For example, care staff and the chef told us the person was eating very little at the current time and we saw from the weight records they had lost 7.4kgs since October 2015. The nutritional risk assessment had not been updated since September 2015 when the person had been assessed as being low risk. We spoke with the kitchen assistant, who provided assistance at mealtimes. They told us about some of the difficulties in assisting this person as they were pushing food away with their tongue. The nutrition care plan had been written in August 2015 and had been due for review in November 2015, but this had not taken place. The care plan did not address the weight loss or give staff any guidance about meeting this person's nutritional needs. We concluded whilst care staff were doing their best the nurses did not provide a clear plan of care for staff to follow.

We looked at another nutritional care plan and saw the person required a soft diet. We also saw an entry which stated they had been seen by the speech and language therapist and were already on the maximum amount of thickener. There were no details in their care plan to advise staff this person's fluids needed to be thickened or details of what consistency or number of 'scoops' which needed to be used. We spoke to the kitchen assistant who told us they had two scoops in their drinks. We spoke to the manager about this and they agreed details about the thickened fluids needed to be in the care plan.

We found staff were not able to rely upon information in the care plans as it was not clear or up to date and this meant people were at risk of not receiving the right care and support. Care staff were mitigating this risk as they knew people well and were responding appropriately to their needs.

People's care records were maintained electronically. The provider told us the electronic records system which was relatively new was, "working well." The care staff we spoke with told us they liked the electronic records system, they said it was easier to record the care and support they had delivered.

We looked at people's care records and found there were care plans in place for all the activities of daily living such as personal hygiene, mobility, eating and drinking, elimination, communication, social and sleeping and for specific needs such as skin care. However, we found the care plans were not person centred, did not always provide clear information for staff about how to support people and were sometimes duplicated and contained contradictory information.

Inadequate

Is the service responsive?

For example, one person had three different care plans for mobility all of which contained different information. One plan stated the person required a mobility aid and one to one supervision but did not specify what type of mobility aid. The second plan made reference to a walking frame and the third plan made no reference to any mobility aids and stated one to one supervision had been discontinued.

In the same person's records we saw a care plan about skin care which stated staff should apply one cream to the person's legs daily and another cream to their sacral area if redness appeared. We looked at the medication records and neither of these creams was on the medication administration record (MAR). We looked in the person's room and saw the cream for their legs was there along with another cream which was not included in the care plan or on the MAR. There was no chart in the room for staff to record the application of the creams.

In another person's records we saw they had a pressure relief mattress in place to reduce the risk of pressure sores. The care plan provided three settings for the mattress – low, medium or high, but did not specify which setting was the correct one for the person. The care plan evaluation dated 12 October 2015 stated the pressure relief mattress should be set at 'medium'. When we looked in the person's room we found the mattress was set at 'firm'.

In another person's record we saw a bed rails assessment which stated they wanted the bed rails in place at night. In their room there was a note on the bed which stated the bed rails should not be put up. We asked one of the care staff about this and they said the person liked the bed rails because they were worried about falling out of bed. They said they thought the note had put on the bed when it was being used by someone else and had not been taken off. We asked the manager about this and they also said they thought the note on the bed had been left on in error.

Information about people's life histories and interests was recorded. However, the care plans we saw about supporting people to meet their social care needs were not person centred. For example, one person's records stated they enjoyed joining activities and should be made aware of all events and activities taking place in the home. There was nothing to show the person was living with dementia or to guide staff on how to tailor activities to the person's individual interests and abilities. This was a breach of the Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the activities co-ordinator who told us they had worked as a care assistant at the home and had been in their new role for about a week. They explained at the moment they were finding out what people liked to do, either individually or as a small group. We saw them playing cards with one person and playing a board game with three other people. In addition to this we saw them spending time with other people discussing what people wanted for lunch. We saw these conversations generated much laughter and enjoyment. The activities co-ordinator explained they wanted to get more structure to the activities programme and were waiting to meet with the manager and people that used the service to decide what people would like to do.

We saw on the notice board a singer had been booked to visit in December 2015 and entertainment had been booked for the Christmas party.

We saw the complaints policy was displayed in the entrance hall for visitors' information. We asked the provider how people who used the service were informed of the complaints procedure as this was not displayed in the home. The provider said relatives were given a copy of the complaints procedure as part of the welcome pack, but acknowledged the procedure was not available to people who used the service. We looked at the complaints received by the home and found it was not always clear what action had been taken in response to the complaint or how the complainant had been informed of the outcome. For example, we saw a written complaint had been made and staff statements had been obtained. There had been a meeting with the complainant but no formal response had been sent. The home's complaints policy stated all complaints are responded to in writing within 28 days. This was a breach of the Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in November 2014 and April 2015 we found a regulatory breach in relation to good governance as there was a lack of effective quality assurance systems in place to ensure continuous improvement of the service. At this inspection we found similar issues remained.

The home did not have a registered manager. The registered manager left in May 2015. The deputy manager took over as manager and was in post when we inspected. The manager was not registered with the Care Quality Commission.

Staff said they enjoyed working at the home; one said, "I love it here." They said they were well supported and worked well together as a team. They said they believed people were well cared for. Staff told us they had regular staff meetings and we saw evidence of this in the records.

We found although the provider and manager were willing and committed to making improvements to the service, the scale of the task and lack of permanent nursing staff had a significant impact on the progress made and the quality of service provided. Although the manager had shown great determination and worked tirelessly to bring about improvements in the service, they had been limited in what they had been able to achieve and we observed the manager was overwhelmed with all that needed to be done. We identified a number of breaches of regulation namely in respect of medicine management, recruitment, training, nutrition, consent, complaints, person-centred care and care records.

At the time of the inspection the home employed two nurses and the rest of the shifts were covered by agency staff. Although the manager tried to ensure consistency by requesting regular agency nurses this did not mitigate the impact on the manager's time and meant they were trying to complete many of the tasks the nurses would normally carry out such as updating care plans and risk assessments.

We found clear and accurate records were not maintained and it was difficult to ascertain people's current care needs from the documentation. For example, we looked at the mobility care plan for one person which stated they were mobile with a walking aid. When we spoke with staff they told us this person now required the use of the hoist for all transfers. We spoke with the manager about this and when she looked at the computerised care plans they found one of the nurses had created a new mobility care plan regarding the use of the hoist, instead of updating the existing plan. This meant there was conflicting information depending on which care plan was read. We saw in one person's care records information about another person who used the service had been entered in error.

The manager acknowledged that they were still learning about the electronic care system and some of the applications which may have supported the manager in their work were not being utilised as the manager did not know how to use them. For example, the manager said they thought the system could provide an analysis of incidents and accidents but did not know how to access this information.

We found there were no systems in place to analyse accidents and incidents. When we asked the manager for this information they showed us a document which listed all the accidents and incidents that had occurred between 1 June 2015 and 31 October 2015. However, this document only listed the person's name, the location where the incident/accident had occurred, the date and time, the type of incident (i.e. a fall) and the name of the staff member who had reported it. When we asked the manager how they could identify trends or themes from this information, they said they couldn't and all they had identified was the overall number of incidents and accidents had reduced each month during this time period. This meant there was no system in place to identify trends or themes or consider lessons learnt to prevent similar accidents/incidents occurring.

We found there was a lack of effective systems to assess and monitor the quality of service provided. For example, the manager told us medication audits were still not being carried out on a regular basis. They showed us the last two audits that had been carried out in October 2015, but these were both incomplete and there was no record of any actions that had been taken to address the issues highlighted. In April 2015, the provider told us that a competency assessment had been developed and would be used to ensure nurses had the skills and competence to manage medicines safely, but this had still not been put into practice. The manager told us there was no system in

Inadequate

Is the service well-led?

place to ensure that agency nurses working within the home were competent to administer medicines. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had not established and operated effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16 (2)

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

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that persons employed are of good character and have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (a) (b) (2) (a)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not ensured that they had obtained the consent of the relevant person to care and treatment, and where the service user was 16 or over and was unable to give such consent because they lacked capacity to do so, had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (b) (i)

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