Acer Healthcare Operations Limited

Parkview House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Parkview House is a residential care home providing accommodation and personal care to up to 53 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 41 people using the service.

People's experience of using this service and what we found

People were not always treated with dignity and respect by staff. We saw occasions when staff supported people in a way that did not uphold their dignity. Some staff spoke about people and their care in a very task focussed way.

People were not always protected from risk associated with their care needs. We saw poor infection prevention and control practice. Medicines were not managed safely and this meant some people missed medicines because they had run out of stock.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. Where people's care plans included restrictions on their liberty, appropriate authorisations had not always been sought. When authorisations were in place the conditions of these authorisations had not been met.

People were at risk of receiving poor quality care because the governance systems were not operating effectively to identify and address issues with the quality and safety of the service.

The provider responded positively when issues with the quality and safety of the service were raised with them.

Relatives told us they thought their family members were safe and felt assured that any issues around potential abuse were escalated appropriately. Staff knew to tell their managers if they had concerns that people were being abused.

There were enough staff on duty. Staff and relatives told us the home had experienced staffing pressures during recent months. The provider had recently completed safe recruitment of new staff. Staff received the training they needed to do their jobs.

People's needs were assessed using a comprehensive system. However, the resulting care plans lacked personalisation and detail. People's dietary needs were met, but their preferences were not always recorded. We have made a recommendation about this.

The provider was taking action to improve the premises to ensure they were suitable for people's needs.

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 good (published 3 October 2019)

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about infection prevention and control measures and whether people's healthcare needs were being met. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with infection prevention and control and ensuring people's healthcare needs were met so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, effective and well-led.

Enforcement
We have identified breaches in relation to Dignity and Respect, Safe care and treatment, Safeguarding adults and Good governance.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in the safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in the effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in the well led findings below.

Parkview House

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 Health and Social Care Act 2008.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Parkview House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Parkview House is a care home without nursing care. 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. They informed us they planned to step down from their current role as registered manager and become a deputy manager. The provider had recently appointed a new manager who was within their induction period. They will be referred to as the registered manager and the new manager respectively throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received from other agencies as well as feedback we had received from

relatives and staff from Parkview House. We reviewed the information we held in our systems as well as information the provider submitted to us. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We made observations of care in different areas of the home. It was not possible to speak to people in detail about their experience of care as the home was experiencing an outbreak of COVID-19 at the time of the inspection; we could not compromise safety measures in place. We spoke with 12 members of staff including the registered manager, the new manager, the receptionist, the regional director, a peripatetic manager, a member of the provider's internal audit team, the maintenance person, four care workers and a housekeeper. After the site visit we spoke to four relatives. We reviewed the care assessments and plans for six people and various medicines records. We reviewed three staff files. We reviewed training records, meeting minutes, audits, complaints records and other records relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

Requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- The systems for preventing and controlling infection were not operating to ensure people's safety.
- We saw staff did not adhere to good infection prevention and control (IPC) practice when dealing with episodes of incontinence and soiled laundry.
- On the first day of the inspection we found the home only had gloves that were not suitable for use during personal care. Although the provider took immediate action to get appropriate personal protective equipment (PPE) the registered manager was not able to explain how they had been able to run out of the appropriate PPE. They suggested it was because glove use had increased while they had an outbreak of COVID-19.
- IPC audits had not identified where some equipment had deteriorated to being in a poor condition that could no longer be cleaned effectively.

The issues identified with IPC and PPE put people at risk of harm and were a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were systems in place to prevent visitors catching and spreading infections. Relatives confirmed they adhered to these systems when they visited their loved ones.
- The home was experiencing an outbreak of COVID-19 during the inspection and we saw they had escalated this appropriately and were undertaking enhanced testing as required. Where necessary for their safety people were isolating in their rooms. Where they were able to other people were maintaining social distancing.
- Despite the outbreak we saw people were receiving visitors in the garden where this was possible and safe for them. Relatives told us they were able to book to see their family members as soon as the outbreak restrictions were lifted.

Using medicines safely

- Medicines were not managed in a safe way and people did not always receive their medicines as prescribed.
- The provider used an electronic system to record the management medicines. This included a daily check of the amount of medicines in stock. We reviewed this system with the provider and found several people had missed medicines due to not having enough in stock. In one case medicines were recorded as not being in stock when the stock count showed they were. Another person's records showed their medicine had not

been administered as prescribed; they were meant to receive the medicine weekly but had received it twice a week. This led to them running out of medicine.
● The medicines plans were not written in line with best practice guidance. They did not describe why people had been prescribed medicines or the support they needed to take them.
● Some people were prescribed medicines on an 'as needed' basis. There were no protocols in place to inform staff when to offer and administer these medicines, or how to decide on the appropriate dosage of variable dosage medicines. The provider submitted some example protocols, but these did not reflect best practice guidance on the administration of 'as needed' medicines.
● Medicines were stored in locked trollies in a dedicated room which was temperature controlled. The room was small and the trollies meant it was crowded. Staff could not access handwashing facilities without moving the medicines trollies.

Medicines were not being managed in a safe way and 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.

Systems and processes to safeguard people from the risk of abuse
● The provider had systems in place to protect people from the risk of abuse, however, staff understanding of safeguarding processes was limited.
● Staff told us they would tell the manager if they were worried people were being abused. However, they did not know who else they could report abuse to. The provider planned refresher training for staff after receiving this feedback.
● Relatives told us they were confident their relatives were safe in the care home.
● The registered manager reported allegations of abuse to the appropriate safeguarding authorities and cooperated with investigations. It was not clear that lessons from investigations were consistently embedded to prevent future incidents.

Assessing risk, safety monitoring and management
● The provider had systems in place to identify and mitigate risks, however, information about risks people faced was limited and in some places information was contradictory.
● For example, one person's summary care plan mentioned a significant mental health diagnosis but the mental health assessment did not refer to this and there was no information within their care file about how to identify and mitigate the risks associated with their diagnosis.
● Staff identified risks associated with people's mobility and risk assessments were in place. However, these lacked details on what steps staff should take to mitigate risks. For example, one person's care plan stated they could get out of the bath with assistance of one carer and aids. However, there were no detail of what aids were required, how the carer should assist and the intervention was described as, "To maintain his privacy and promote his dignity."
● Despite the lack of detail in records, we saw staff supported people safely with moving and handling.

Learning lessons when things go wrong
● The systems for ensuring lessons were learnt when things went wrong were underdeveloped.
● There were regular meetings where information about incidents was shared with staff. However, there was no root cause analysis to identify potential causes or themes in incidents that occurred.
● There was a system of completing a "resident at risk" form to identify and respond to infections, wounds and other areas of concern. These were not operating effectively and the sections relating to management oversight were blank. The measures in relation to a variety of different infections was recorded as "Full PPE" including infections that would have required additional measures to resolve them such as urinary tract

infections.
● Incident records did not show what actions were taken to keep people safe. For example, an incident record following a fall and development of a bruise recorded that healthcare services had not been able to support as the person was not in the system. There was no further information in the incident record to show what actions were taken in response to the incident.
● The provider recognised there were issues with the effective governance of incidents.

Staffing and recruitment
● Staff were recruited safely in a way that ensured they were suitable to work in a care setting. There were systems in place to ensure there were enough staff to meet people's needs.
● Staff and relatives both told us they felt there were not always enough staff. One relative said, "They seem very short of staff." Another relative said, "They [staff] are pushed, really they are short staffed. They are having to work a lot more hours than they should. For their own sake as well as our family's they need more staff."
● We saw that staff did not always work effectively together to ensure people's needs were met. For example, we saw that when people had finished their meal and wanted to be moving staff were all cleaning up from the meal and this meant people were attempting to mobilise in unsafe ways.
● The provider recognised they needed to ensure a balanced team of staff were working to ensure people's needs were met. We saw they were taking action to recruit additional staff and deploy staff more effectively.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

Requires Improvement: This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to eat and drink enough to maintain a balanced diet. However, the mealtime experience was not a pleasant or engaging time for everyone.
- On the first day of the inspection we saw two people had been left to fall asleep at the table during lunchtime. When staff intervened to prompt these people to eat they did not do this in a kind or compassionate manner. A care worker stood over the person and told them to "Eat it, eat it". They later told the person off for trying to use a knife to eat their pudding then said loud enough for the room to hear, "That's them on one for the rest of the day now, can't eat it with a knife can they." Another staff member was able to give them appropriate cutlery without drawing attention to it.
- While this was taking place, another person had been incontinent. Rather than supporting the person subtly and sensitively staff spoke loudly about this fact, so other people were commenting on this person's incontinence. It then took over 10 minutes for this person to be supported with personal care. The chair and floor was left for another ten minutes, while others were eating. Several people had to be stopped from sitting in the dirty chair.

This shows people were not being treated with dignity and respect. This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relatives gave us mixed feedback about the quality of the food. Some said their family members were happy with the food, but others said the variety and quality of food had deteriorated. One relative said their family members cultural preferences were no longer met by the menu provided.
- We observed a mealtime in another area of the home and saw people were being offered choices about what they wanted to eat and drink. Where peoples' preferences couldn't be met immediately the new manager told them it would be added to the menu.

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 MCA 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).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The systems in place to monitor deprivations of liberty and conditions attached to them were not operating to ensure people's rights were protected.
● The registered manager had applied to the appropriate authority to deprive people of their liberty. However, it was not clear they had followed up when authorisations were delayed and they had not ensured conditions attached to people's DOLs authorisations had been met.
● One person's DOLs authorisation had only been extended for a short period of time due to previous conditions not being met. At the point of inspection, two months after that expiration the conditions had still not been met.
● Three people's DOLs had expired and new applications had not been made. Their care included restrictions on their liberty.

The above issues with failing to meet conditions on DOLs and restricting people's liberty are 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.

● Care plans showed people's capacity to make decisions was assessed regularly. People were assumed to have capacity to make decisions about their care and treatment. Where people lacked capacity care files showed how decisions about their care were made in their best interests.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had a robust system for ensuring people's needs were assessed in line with standards, guidance and the law. However, care plans lacked personalised details and sometimes contained conflicting information.
● The provider's system allowed staff to record an observation, goal and intervention for each area of need, such as personal hygiene, mobility, eating and drinking. However, the way care plans had been completed meant some needs did not have a linked intervention, very few had goals identified and some parts of care plans conflicted with others. For example, one person's dietary plan included that they liked smoothies and orange juice, but their goal was stated as, "[Person] does not like sweet drink." This is not a goal.
● Another person's plan contained conflicting information about their communication. The plan stated they were "non-compliant with their activities of daily living." It also stated they had, "little speech and cannot express [their] thoughts and wishes clearly." However, the intervention stated they, "Requires no assistance with speech." This person may not have been receiving the communication support they needed due to this confusing picture of their needs.
● Care plans were high level descriptions of support that lacked detail. For example, several care plans included that people liked to be supported with their hair care, or facial hair but provided no details about the nature of their preferences.

We recommend the provider seeks and follows best practice guidance about ensuring needs assessments

are personalised to people's individual needs.

● Relatives told us they had been involved in the assessment of people's needs when they moved into the home.
● Staff regularly reviewed and updated people's needs assessments. Staff told us most of the people they supported were able to explain how they wished to receive their care.

Staff support: induction, training, skills and experience
● Staff had received the training they needed to perform their roles, however, the training had not always been effective as staff practice fell short of expectations on occasions.
● We saw staff behaved in ways that suggested their IPC training, and training in supporting people with dignity had not been effective. The provider immediately scheduled refresher training in these areas.
● Staff told us they received the training they needed to perform their roles. Staff specifically said they had received significant support to learn how to use the computerised systems the provider had adopted. One staff member said, "I've had more certificates in the last year than I ever got in school."
● Most of the relatives we spoke with told us they thought staff had the training they needed to support their family members. However, one relative felt there had been a deterioration in the last six months. They reflected there had been a high turnover of staff and this had affected their confidence in staff skills.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff worked with other agencies and healthcare services to provide people with effective care. However, records of how this support was requested and received meant it was not always clear appropriate actions had been taken in a timely manner.
● Relatives told us they weren't always kept informed when their family members needed additional support, or accessed healthcare services. One relative said, "The communications [about their relative's health] hasn't always been easy. I prefer to do all the appointments because the staff don't know the medical history. They were happy when I said I'd take the lead."
● The provider told us they had been having difficulties with their GP service and had recently made the decision to change GP. Relatives told us they had not been involved in this decision, some of the relatives we spoke with did not know this had happened. One relative said, "First I heard of it was when I got an email last week to say visiting would be back, and then in the last paragraph it said they had been told to inform us the GP changed the week before."
● Staff were meant to record information about health appointments as a specific type of note. However, they had been recording them as daily notes. This meant it was not clear that concerns about people's health had been appropriately escalated in a timely way. The registered manager was able to show email trails of issues being escalated when specific cases were followed up.

Adapting service, design, decoration to meet people's needs
● The premises were arranged to ensure they were suitable for people's needs. The provider had a plan in place to address where the building was not suitable for people's needs.
● Some rooms had en-suite bathrooms with showers. However, these all had a raised step which meant people could not use them safely. When this was identified during the inspection the provider immediately sought quotes from tradespeople who could make the en-suite facilities accessible for people.
● During the COVID-19 pandemic the home had repurposed some areas of the home to facilitate visiting and social distancing.
● Relatives told us people were able to decorate their rooms to suit their tastes. They told us people were able to access all areas of the home they wished to.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement.

Requires improvement: This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's quality assurance systems were not operating effectively to identify and address issues with the quality and safety of the service. The management team was in a state of change at the time of the inspection and the provider was very open that the quality in some areas did not meet their expectations.
- The provider had a system of audits to monitor the quality of the service. However, these had not identified the issues we found during the inspection. Where shortfalls were identified through audit the action plans were ineffective. A care plan audit showed some shortfalls with care files had been found, however, the action plan assigned the action of addressing the shortfall to 28 named staff members.
- The medicines audit completed in March 2022 had not identified the issues we found with medicines records and 'as needed' protocols. The audit had two actions which were not clear as they described the issue not the solution. This was then assigned to over 40 named staff members.
- The infection control audit included a "pass" in relation to root cause investigations being conducted into outbreaks of infections. We asked for the root cause analysis for an outbreak and were told there was not one. We were shown incident reports which did not include any analysis of the potential root causes of the outbreak or ways of preventing recurrence.
- Relatives told us they felt there was room for the management of the home to improve. One relative said, "It could all do with a bit of tightening up." Another relative said, "I think they could do better with leadership."
- Staff gave us mixed feedback about the management and leadership of the home. One care worker told us "It's getting organised now. It's been in a bit of a muddle recently." Some staff told us they felt they had been left unsupported. One care worker said, "It hasn't been well run, we've really been struggling, and now new people are coming in like a tornado. We've been working really hard, but we were just left to get on with it before."

The failure to identify and address issues with the quality and safety of the service put 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.

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

outcomes for people
● The culture in the home had become task focussed and did not focus on people and their needs.
● We saw undignified care being delivered and the way staff spoke about the people they supported was not always caring. For example, staff referred to people by their bedroom numbers rather than names and spoke about people in terms of their needs.
● Some relatives told us they were concerned their family members were not consistently engaged by staff. One relative told us their relative had been left sat facing a wall because staff hadn't supported them to reposition their chair.
● People and their families were not consistently involved in decisions about their care, and care plans rarely contained specific goals for people that focussed on outcomes. Relatives were told about changes by email but this was not an effective way of communicating with all relatives.
● The provider responded promptly to our concerns about the culture that had developed and scheduled training sessions and meetings with staff to promote a more positive, person centred culture.

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 understood their responsibilities under the duty of candour.
● Relatives told us they were usually informed if things had gone wrong. Relatives told us that if they made complaints these were responded to appropriately.
● Notifications about events and incidents that took place within the service were submitted as required by law.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider had systems in place to engage people, their relatives and staff but these were not always meeting people's needs.
● Staff meetings took place but records showed these were often in reaction to concerns being raised. Staff raised issues such as staffing levels and absence management but there were no actions recorded to show staff their concerns had been listened to.
● Relatives and residents' meetings had been taking place on an individual basis rather than as group meetings. Relatives told us they received regular newsletters that told them about things that had happened in the home.
● Staff told us there used to be regular whole staff team meetings with a social element but these had stopped due to the pandemic. Other staff told us they had not been invited to staff meetings until the inspection started.

Working in partnership with others
● The provider was working with other organisations, but records did not always show this work.
● The registered manager told us they worked closely with the local authority and other organisations.
● The provider deployed additional support to the home from their audit and support teams.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not being treated with dignity and respect. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks associated with infection prevention and control and medicines were not appropriately identified and mitigated. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People's care plans contained restrictions on their liberty which had not been properly authorised. Conditions on other people's authorisations had not been met. Regulation 13

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not operated effectively to identify and address issues with the quality and safety of the service. Regulation 17(1)