Sanctuary Care Limited

Parkview House Residential Care Home

Inspection report

12 Houndsfield Road
London
N9 7RQ

Tel: 02076973301
Website: www.sanctuary-care.co.uk/care-homes-london/parkview-house-residential-care-home

Date of inspection visit:
29 May 2018

Date of publication:
26 July 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We undertook this unannounced inspection on 29 May 2018. Parkview House is a care home which is registered to provide personal care and accommodation for a maximum of 45 older people with dementia. The home is on two floors and divided into 5 units or "clusters". At this inspection there were 43 people living in the 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.

At our last inspection on 15 and 17 July 2015 the service was found to be compliant with regulations and was rated 'Good'.

The home had a registered manager. Like registered providers, registered managers are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act and associated Regulations about how the service is run.

People told us they were safe living at the service and staff were kind. Health and social care professionals, relatives and people living at the service told us the staff were skilled and knowledgeable and able to provide suitable care.

We were concerned that staffing levels at night were insufficient to meet people's needs, but the provider increased staffing levels at night the day after the inspection.

Risk assessments were in place to guide staff in safely caring for people, and care plans were up to date and covered a wide range of needs. Staff understood how to safeguard people from abuse and the service had appropriate procedures and processes in place.

Recruitment of staff was safely managed, and staff received regular supervision and training to support them in their role.

Medicines were safely stored and managed.

People told us they were happy with the food.

There were a range of activities at the service to meet people's needs.

The service had appropriate documentation in place in relation to consent and compliance with the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this

practice.

A range of quality audits took place and the management of the service was praised by health and social care professionals, relatives and people living at the service.

We have made a recommendation in relation to staffing levels.

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. There were insufficient staff to meet people's needs at night at the time of the inspection, but the provider increased staffing levels at night, the day after the inspection. We have recommended staffing levels at all other times are reviewed.

The service reviewed accident and incident forms and could show learning for individuals, but could not show learning across the service from trends.

Staff recruitment was safe. The provider had a safeguarding procedure and staff had received training and knew how to recognise and report any concerns or allegation of abuse.

Risk assessments were detailed and updated regularly.

Medicines were safely managed.

Is the service effective?

Good

The service was effective. Health and social care professionals, relatives and people living at the service told us the staff were skilled and knowledgeable.

People's health needs were met and the service worked in partnership with health and social care professionals.

Care records showed the service were working in line with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff understood the importance of obtaining consent before providing care.

People told us they enjoyed the food.

Is the service caring?

Good

The service was caring. We saw staff were kind and caring to people and this was confirmed by health and social care professionals, relatives and people living at the service.

People were involved in their care and staff asked peoples' views

as to how the service should be run.

People's religious and cultural needs were met.

Is the service responsive?

Good

The service was responsive. Care plans were detailed, up to date and person centred.

Sufficient activities were available for people to be involved in.

The service provided high quality end of life care.

Complaints were dealt with in a timely and appropriate manner.

Is the service well-led?

Good

The service was well-led. The registered manager and deputy manager were well regarded by the people at the service, their relatives and health and social care professionals.

Staff told us they were well supported in their role.

Quality audits took place at both a service and provider level.

Parkview House Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 29 May 2018 and was unannounced. The inspection team comprised of two inspectors, and two experts 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.

Before the inspection we reviewed relevant information that we had about the provider including any notifications of safeguarding or incidents affecting the safety and wellbeing of people. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 13 people living in the home and six relatives on the day of the inspection.

We also spoke with five care staff, the regional manager and the deputy manager. The registered manager was on annual leave at the time of the inspection.

We observed care and support in communal areas and looked at the kitchen, garden and people's bedrooms.

We looked at six people's care records. We reviewed five staff recruitment records, staff training and induction records.

We checked the maintenance records of the home, accident and incidents logs, audits and safeguarding records. We checked medicines administration records and medicines storage, complaints, accidents and incidents and how the service supported people with end of life care.

Following the inspection, we spoke with five additional relatives and or friends, and three health and social care professionals. We also obtained further information from the registered manager.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe living at the service. They told us "I feel safe here. We have a good time; the staff know what to do and we all get along." And "I feel safe. The staff treat me very satisfactorily." Relatives told us: "It's safe for her here." And "I think he's safe here with the staff and with other residents."

We could see the service had systems and processes established in relation to safeguarding and staff could tell us the types of abuse and how to safeguard people. Staff told us "We have to safeguard residents from abuse as they are vulnerable. There are people who may take advantage." Staff understood how to whistleblow if concerns were not addressed. "I would report to the manager, CQC, police, safeguarding at the council." The registered manager responded appropriately if concerns were raised and worked in partnership with the local authority and CQC.

At the last inspection there were two staff on each of the five units in the day and one staff member on each unit at night, with an additional floating staff member. During the day the deputy and registered manager also offered support to units if required.

At this inspection we found the staffing levels had been reduced at night and there was no longer a floating staff member to offer support if a person was unwell, or needed two people to care for them. An audit by the provider had noted issues with staffing levels in November 2017 which meant that for 20 minutes people had been left unattended whilst a staff member supported staff on another unit. The registered manager told us this was during the day when a staff member had gone on their break and another staff member had needed to get some equipment.

The day after the inspection the regional manager reviewed the dependency levels of the service and agreed that an additional staff member at night should be employed to offer support across the clusters with immediate effect. We checked dependency levels and could see that in the last 12 months people's dependency levels were increased in a number of the units. There were some vacancies in other units, but the physical layout of the building, with a distance between units meant that staff could not easily provide staff cover across the units.

People told us they thought there was enough staff. They said If you want something you can call and they come quickly. We live like a family." And "On the whole they come quickly if I call."

Some relatives told us they thought that there was not always enough staff at busy times, for example, when people were getting up, or when staff went on a break and this left one staff member covering the unit during the day. Some relatives identified staff cover at the weekend as stretched. They told us "sometimes there may only be one person on at a time, and many of the residents are prone to falls, and now my [relative] is in that category". And "Some people need two staff to go to bed and there's only one on." Another relative told us "At weekends they definitely need more staff." One staff member told us "Our cluster is high risk. We do okay. But to be honest for two hours in the day we could do with an extra floating person."

We discussed these issues with the registered manager who told us there were the same number of care staff on during the weekend as during the week, but managers did not usually work at the weekend so were not available to offer additional support to care staff. The registered manager and regional manager told us they would consider this feedback from relatives and staff and consider how to address the issues raised.

We recommend the provider reviews all staffing levels at the service.

We could see that some learning took place from accident and incident logs, but further analyses was required to maximise learning and minimise future accidents and incidents.

Reviewing accidents and incidents over the last four months we could see that the service responded appropriately when people fell, by updating their risk assessment and putting in additional equipment if necessary. However, the service did not appear to have acted on the collated information which noted that from February to May 2018 'falls seem to happen at our busiest times or when staff are assisting other residents" or when there were "staff breaks". This showed us the service had not addressed the question as to whether falls could be reduced by utilising staff differently, or indeed there were enough staff to care for people safely at busy times.
We discussed this with the registered manager who told us they would look at accidents and incidents in conjunction with issues raised above in relation to staffing levels, to minimise further falls where possible.

Although the service had systems in place to check the service was clean throughout we found there were some issues with infection control. For example, there were no bins in communal bathrooms for disposal of waste hand towels. We asked staff what happened with soiled hand towels but they did not know. In one bathroom we found a plastic bag tied to a handrail. We found there were no hand towels in one communal bathroom as staff told us one person used them to block the toilet. We discussed these issues with the regional manager who immediately ordered bins for the bathrooms and a hand drier for the bathroom where it was difficult to leave paper towels.

We also found a smell of urine in two of the units. The furniture in one of the units was covered in fabric and we found the foam cushions had been covered in plastic bags to minimise any spoilage penetrating the cushion. This was not entirely effective.

The regional manager assured us new furniture would be ordered for this unit and as the carpet was difficult to keep clean this would also be changed. Other units had fabric chairs but these were more easily wiped. The regional manager told us that replacing these would be part of a programme of improvements.

We saw staff used protective clothing when providing care and serving food to minimise the spread of infection.

Staff recruitment was safe. All criminal record checks, references and right to work in the UK documents were in place. The service had a system to ensure all recruitment checks were in place before a new staff member started work as an additional quality assurance measure.

Risk assessments were in place and covered key risk areas. These included falls, moving and handling and risk of becoming a missing person. One person was at risk of absconding and their risk assessment included a photo and physical description of them. Risk assessments provided guidance to staff and included important information about triggers for anxiety, for example, worrying about belongings lost, from the past.

Medicines were stored and administered safely. The medicines room had been newly refurbished and was

clean, cool and uncluttered, with temperatures checked and recorded. Controlled drugs were stored appropriately and all stocks tallied with MARs. Records of daily stock checks confirmed this. Staff in one unit audited the medicines in another as a cross check.

Medicines given when needed (PRN) were appropriately managed with protocols in place on people's MAR files. The reasons for administering PRN and outcome was recorded.

Where medicines were administered covertly there was appropriate documentation in place which was reviewed regularly. Body maps were in place for topical medicines and records completed to confirm they had been applied. Homely medicines were kept separately and agreements were in place, signed by the GP, with advice as to when to use.

Only trained staff administered medicines and they had a yearly competency assessment and observation of practice. An external pharmacist had audited medicines recently and actions they had identified had been implemented.

People told us "I take tablets sometimes. They do tell me what it's for, like nerves or something." And "I'm taking tablets. I've been told what they're for but I can't remember now. I take them at the same time each day."

Building maintenance checks took place to ensure the safety of the building. Equipment checks including hoists, slings and wheelchairs also took place. Fire equipment was regularly maintained and we could see that fire drills took place in the day and night to ensure staff were competent to deal with an incident whenever it may occur.

Some areas of the building had been recently decorated and some bathrooms had been upgraded with new fittings and better drainage. There remained some areas of the building including en-suite bathrooms which required upgrading. This was scheduled in the coming year.

Good

Is the service effective?

Our findings

Relatives highly praised many of the staff's skills in caring for their family members. One relative told us they felt that the staff were skilled at handling their loved one when they could be "difficult". "They are patient with him. They cajole or encourage him if he decides he doesn't want a shower or anything." We were told staff were "exceptional" that they "worked together" with family members. One relative told us "90% of them had the skills and knowledge to care for [their relative]." Family members told us specific staff members were "excellent"

New staff received an induction, regular supervision and training to support them in their role. Induction included a mix of classroom , e-learning, shadowing and time to read the providers' policies and procedures. New staff were expected to complete the Care Certificate if they had not already obtained it. The Care Certificate is a national qualification setting out best practice in care. Competency assessments in areas such as moving and handling, personal care, assisting with mealtimes, oral care also formed part of induction. All induction records were signed off and regular meetings took place throughout the induction period.

Bi-monthly supervisions were personalised to the staff member, objectives were set and achievements discussed. Areas for improvement were identified and learning goals set. We noted that team leaders responsible for supervision of care staff did not have allocated time to do this, but had to work around caring responsibilities. One staff member told us "I pre-plan the supervisions and arrange on rota. Staff maybe come to the cluster lounge. I do approximately two per week."

Mandatory training included moving and handling, falls, bedrails, dementia, end of life, fire safety, first aid, food safety, and health and safety. Safeguarding and the Mental Capacity Act 2005 was covered in induction and periodically refreshed. Staff administering medicines were all trained and had a yearly observed competency assessment which was documented.

Most people and their relatives told us the food was good and that there was choice. People said "The food is excellent. There's a good choice." And "We have good food here. Sometimes we have chicken curry which I like." Only one person was dissatisfied and said "The food is repetitious. I'd like more variety. I complained about it a while ago but it hasn't changed." Relatives told us, "Food is good, she'll never go hungry". Only one relative told us, "The quality of food is not as good as it once was. The portions of food are too small."

We noted that the service did not use pictorial menus, but they did have tasting plates on occasion for people to try out dishes. The regional manager told us they would introduce pictorial menus as this would be useful for people with memory problems and word finding issues.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 found the service had systems in place to prompt applications for DoLS and care records had detailed mental capacity assessments on file. There were mental capacity assessments on care records in relation to specific decisions. This showed that the staff were aware that people could consent to some decisions but not others. These were reviewed and updated regularly.

Staff understood the importance of gaining consent, one staff member told us Some people are unable to make decisions for themselves. I always ask for consent. No day is ever the same for someone with dementia." Another staff member told us "We ask them what they would like to wear. Whether they want a shower, bath or full body wash." This was confirmed by people living at the service. They told us "If you want a shower you can have one." Another person told us "I can have a shower whenever I want."

We could see from care records that people had good access to health care. Health professionals praised the service and the vigilance of the staff in noticing if people were not well and taking action. They told us the service worked in partnership with them to ensure people had healthier lives. Relatives confirmed that the service kept them up to date with any health issues and if they raised any health concerns, these were followed up immediately. "He sees a doctor if needed and they would ring us up if anything was wrong."

One relative gave us a good example of the service working in partnership with them to obtain the best health care for their relative. They told us the service had given them an opportunity to decide if their relative should go to A&E late at night, following a fall. They appreciated the opportunity to discuss the options available and to weigh up the pros and cons of waiting for hours in the middle of the night at A&E, when the person was confused.

People who lived there told us they had visits by a doctor, dentist, optician and chiropodist. "I saw the doctor last week. He examined me and told me what's wrong. I've got eye trouble. The optician came two weeks ago and someone came to do my toenails."

The building is on two floors, separated into five distinct units. There is lift access to the first floor. There is a large communal space for people to walk around inside the building and we saw numerous people using this space throughout the day. There are several garden areas, the largest had been upgraded recently and provided a pleasant space to sit out in.

Good

Is the service caring?

Our findings

The people living at the service told us, "The staff here are very kind." "The staff know me in and out and they encourage me." A third person said, "The staff are patient." Another person told us "Every day they ask me about myself in a friendly way."

We saw many kind and caring interactions between staff and people living at the service. Relatives confirmed many staff were kind and caring. One relative told us the staff were genuine in their kindness and they sometimes came into the unit to find staff dancing with people as there were songs on the radio people liked.

We saw members of staff at different times of the day knocking before they entered residents' rooms and carefully assisting people to get up from chairs, go to the toilet or to walk to their rooms. Without exception, we saw these things were done by staff with patience and with expressions of kindness and reassurance.

Relatives confirmed staff were caring and kind. They told us "They are very caring. They cuddle her and she is very happy." And "My family feel that the staff are very approachable."

People and their relatives told us staff knew about their backgrounds, and care records detailed people's personal histories. One person told us "They know I was a floor layer." A relative told us "They know he was a council worker because one or two of them have spoken to him about it."

Staff told us although they primarily worked on one cluster they also helped staff in other clusters and could tell us about the needs of a person from another unit. For example, one staff member told us "[Person's name] is always walking about. He comes onto Groveland and we get to know him. Its nice people can do that." A relative told us they were impressed how staff supported each other across the units and this kindness to people and staff benefitted all the people living at the service.

Health and social care professionals praised the service. One health professional told us the service saw beyond the dementia to see the person.

For the most part we found people were treated with dignity and respect. However, the location of communal toilets opening off the living rooms was not conducive to providing dignity to people. For example, we saw one person left privately to use the toilet, but due to their confusion after a short while they opened the door looking very anxious and in an undressed state. The staff member rushed back to help the person and closed the door. The location of the toilet off the living room was not ideal, and there was a malodour on occasion from the toilet. One staff member told us "We prefer to take people to their room. They tend to use the bathroom in their rooms. It's a poor design." The regional manager told us the service was planning to make improvements in the coming 12 months to the design of communal bathrooms and the toilets would be included in these improvements.

People's cultural and religious needs were recorded on care records and people told us their needs were

met. One person who was Christian told us she attended regular services with her family. "I love the service here." Although another person told us whilst there were occasional religious services at the home, they would like more. The service celebrated other cultures "We recently did cruise week to celebrate different countries. We dressed up and did meals."

People signed their care records and most people told us they were involved in care planning. One person told us "They talk to me about what's wrong so I understand." Care records emphasised people's abilities as well as their needs.

Good

Is the service responsive?

Our findings

The service provided person centred care in many ways.

Care records were detailed, up to date and covered a wide range of needs including people's mobility, personal care needs, cognition and mental health. We could see that staff had collated extensive knowledge of people's needs and their likes and dislikes and routines were recorded. This was especially useful for people with memory problems.

People had key workers who got to know their needs and wishes. Staff told us "We get them presents for their birthday. We liaise with their families, check they have clothing. We have good families here." Relatives praised many key workers and told us they were "excellent" and "ten out of ten". People told us "I can go to bed when I like."

There were a range of activities taking place at the service. These were organised by two activities workers with the support of care staff. There was an activities room with a range of activities taking place including arts and crafts, bingo and games. There was a community choir, musicians and music events taking place monthly. The management team and activities workers arranged a lot of fundraising events to fund people going for outings including the seaside. Families told us the events enabled them to join in and be part of the community which was positive.

There were mostly positive comments about the activities, particularly from relatives and friends. People told us "I like the activities here, especially the music and movement." And "I like the activities; we have a laugh." A third person told us "I like it in the garden. I go outside whenever its nice." However, two people told us "The activities are OK but they don't appeal all that much."
And "There are not that many activities here."

There was not always a range of games or sensory items for use in the smaller lounges that people could play with when they wanted. However, the registered manger told us they were reviewing sensory and reminiscence equipment and intended to buy more in the coming months. The registered manager also told us that staff spent ten minutes of one to one time, with a person on their unit every day. They may walk them around the building, talk with them, or read to them. This is to ensure that people have some personalised support.

We found the service had a complaints process in place and responded appropriately to complaints raised. Actions taken were noted with the complaint record where upheld. For example, where a complaint was made that a person was taken to the nearby doctors on a wet day without appropriate cover, the action was that umbrellas were now available at reception. Where people had issues with missing clothes, people were reimbursed.

There was also an anonymous 'Grumbles' box at reception where people or visitors could anonymously raise concerns informally. Relatives told us they had no qualms at making a complaint or raising issues.

They found the keyworkers, team leaders and members of the management team very approachable, and responsive to any issues raised. "I know, the manager but they are all approachable." People who lived there told us "I think I know the manager." And "I don't know who the manager is. I would try to speak to a member of staff if I wanted to complain." We saw numerous compliments from friends and family members thanking the service for caring for their loved ones.

A staff member told us "We pride ourselves on our end of life care." The service had achieved Gold Standard Framework accreditation for end of life care on three occasions. The latest award was at the highest level possible. A health and social care professional told us the service excelled at this type of care. We saw specific end of life care plans were developed. One, for example, detailed contact with district nurses regarding end of life medicines, pressure care, oral care, eating and drinking. Final wishes and funeral arrangements were also documented. The care plan noted, "Ensure [person's] hair is combed every day. She is a very proud lady." It was documented that the persons daughter was contacted and present when the person passed away. The service was in the process of working with all the people and families to set up end of life care plans if they chose to.

The service arranged funerals for people who had no families and held wakes at the service for people to mourn and arranged flowers and other final matters. The service told us they had a good working relationship with the undertaker to ensure things ran smoothly.

Good

Is the service well-led?

Our findings

The provider had as their mission statement 'Keeping kindness at the heart of our care.' The values the provider and the service were working towards included; to deliver personalised care; to treat people with dignity and respect and to ensure that residents can live happy, contented lives. We could see the service was working to achieve these.

There were many ways in which we could see the service was well-led.

We could see that audits took place at the service. These included medicines, environment and care plans. Where actions were identified they were loaded into a Service Improvement Plan which was updated when actions were completed. The plan was periodically signed off by the regional manager once they satisfied themselves actions were completed. The provider also carried out audits of the service to check the quality of the service.

Regular staff meetings took place which included night staff. The meetings covered issues of good practice, expectations of staff and addressed any staff concerns. Additional meetings took place related to dementia care and the registered manager and deputy held brief morning meetings to share key information relevant to the running of the service that day.

Staff told us they felt well supported and enjoyed their work. They told us of the management team. "They are brilliant. Really good and nice." "They are here for the residents. They always make sure to support me. They always feed back to me." Other staff told us "We have an open culture. We can say what's on our minds." And "Staff feel valued. A month ago, we had a quiz and the winning team won a meal out." Another staff member told us "I love it here. I went somewhere else for a while but that's why I came back and I've been here 10 years now." "Best thing here? We genuinely care." "We make them feel at home. We make them feel worthwhile. [Person] said to me, 'You make me feel worthwhile.' We care for them really well."

There was minimal staff turnover and where there was annual leave or vacancies, staff told us "We help on days off. We chip in, in order not to use agency."

We asked staff if there were any improvements they could identify. One staff member told us "Not a lot on the care side. The paperwork is astronomical. A lot of the paperwork is on the computer. We have to leave the cluster if we are doing anything on the computer." Another staff member told us "Sometimes we have to meet deadlines with care plans. We always find time to care for residents. Sometimes we come in on our day off and work on care plans." We discussed this with the registered manager who told us there was a lap top computer available for use by staff. They would make sure staff were aware this was available and see if there was any other way to support them with care planning documentation.

Provider surveys showed that relatives and people living at the home were happy with the service. The most recent surveys in 2016 and 2017 showed satisfaction levels high at over 90% in key areas. People were emphatic in their praise of the service telling us "This is a good place to live, of course it is!" "Yes, I would

recommend this place. I think other people would be happy here." And "It's well-run. They're on the ball! I would recommend it here." Any issues raised were added to the service action plan. The next survey is due to be held in the coming months.

Relatives praised the registered manager and the deputy manager and their ability to run the service well. One family member said, "the registered manager is superb" another told us the management "go above and beyond". Relatives told us communication was generally very good, and that they had "great admiration for the staff." There was a regular newsletter to keep all stakeholders updated.

Although people and their relatives were happy with the service regular residents' meetings were not taking place. People told us "I don't know if they have any meetings here." The registered manager told us that less formal ways were used to get feedback from people. For example, following an event people were asked if they enjoyed it and what could be better; following some activities people gave feedback. They also told us they asked people's views about food and the menu. They undertook for formalise more of these discussions and meetings to evidence people's involvement.

The registered manager told us there were areas they were focusing on to make improvements. These included improving the handover process from one shift to another, including the use of new handover booklets as there was no time available within the rota for handover to the whole staff team; only team leaders attended a fifteen-minute meeting. Also, the service did not have a pen picture of people's needs for when they occasionally used agency staff.

The regional manager, who was newly in post told us they were reviewing the supervision process for team leaders and would be working with the registered manager, deputy and staff to evaluate what was working well and where improvements were needed across the service.

The provider had a plan to introduce a new electronic care system in the coming months to provide easily accessible information for staff and improve systems for recording and quality assurance audits. The regional manager told us they would factor in additional staff time to implement the system and would gradually roll it out to ensure the quality of the care was not affected.