Matt Matharu

Parkview Residential Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 2 and 5 February 2015 and was unannounced. This meant the staff and provider did not know we would be visiting.

Parkview Residential Home provides care and accommodation for up to 26 people. On 2 February 2015 there were 22 people using the service and on 5 February 2015 a new person had moved in making a total of 23 people.

We last inspected the home in May 2014. At that inspection we found the service was meeting all the regulations that we inspected.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 told us they felt safe. We found people's medicines were not managed or administered safely.

Summary of findings

We found infection control was not conducted effectively therefore putting people who used the service, staff and other people at significant risk of acquiring or transferring infections.

The provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

Staff we spoke to had a good understanding of safeguarding and knew how to report concerns. All of the staff we spoke to reported that they did not have any concerns about the safety of the people living in the home.

Although staff understood about supporting people to make choices and decisions they had limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and how the principles of the legislation applied to people who used the service.

Training records were up to date and staff received regular supervisions and appraisals, which meant that staff were properly supported to provide care to people who used the service.

Care plans were reviewed regularly and reflected people's changing needs. This meant staff had access to up to date information about how people should be supported and cared for.

We saw evidence in care records of cooperation between care staff and healthcare professionals to ensure people received effective care. For example, one person had been referred to the Speech and Language Therapy Team (SALT) as they were having difficulty with eating.

We found people did not receive sufficient engagement or stimulation. People received very little interaction from staff and were unsupervised for long periods.

People told us family members and friends were able to visit them at any time of day. We were told they were welcomed into the home by the staff and offered drinks and biscuits.

We examined infection control, health and safety and medicines audits. We found these were not comprehensive and did not highlight the concerns we found. This meant that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

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?

Inadequate

The service was not safe

People and others who had access to the premises were not fully protected against the risks associated with unsafe or unsuitable premises since not all areas of the home were suitably designed and the provider was failing to ensure that maintenance work is carried out in a timely manner.

We saw that resident's medicines were not stored or administered safely.

We noticed that infection control audits were carried out. These however, did not always identify the concerns that we found therefore actions were not put in place.

Is the service effective?

Inadequate

The service was not always effective

We found the environment did not support the needs of people who had dementia.

Staff we spoke with were not able to tell us what the Mental Capacity Act 2005 was and when Deprivation of Liberty Safeguards should be applied to a person.

We saw from people's care plans the full involvement of external medical professionals including SALT, community nurses, dietitians and dentists.

Is the service caring?

Requires Improvement

The service was not always caring

We observed varied levels of interaction between staff and people who used the service, both positive and examples of areas that required improvement.

People told us family members and friends were able to visit them at any time of day. Family and friends were welcomed into the home by the staff and offered drinks and biscuits.

We found that people's privacy and dignity was respected by the staff team.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The registered manager told us care plans were reviewed monthly and this was confirmed by the records held. We noted when people's needs changed before a review was due, the care records also were reviewed for any possible changes which may have been required.

Summary of findings

We found people did not receive sufficient engagement or stimulation. People received very little interaction from staff and were unsupervised for long periods.

Relatives told us they knew how to complain and would have no hesitation in doing so. They told us they would know if something was upsetting their relative.

Is the service well-led?

The service was not always well-led.

The provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

People and relatives told us they felt the service was good because staff responded quickly when needed, care was good and meals were ample and of good quality.

Requires Improvement

Parkview Residential 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 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.

We visited the service on 2 February 2015 and 5 February 2015. The inspection team consisted of three adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed the information we held about the service, including any notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority safeguarding team, Commissioners for the service, the local Healthwatch and the Clinical Commissioning Group (CCG).

During this inspection we spoke to 11 people who live at Parkview, four relatives, four care staff, the deputy manager and the registered manager.

We carried out an observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We undertook general observations of how staff interacted with people as they went about their work.

We looked at six people's care plans and 10 people's medicines records. We examined four staff files including recruitment, supervision and training records. We also looked at other records relating to the management of the home.

Inadequate

Is the service safe?

Our findings

We found significant problems with the condition of the premises.

We observed in one shower room that the shower tray was damaged and the plastic covering was peeling off in places. In addition, some of the tiling around the shower was cracked and damaged, the toilet frame arm rest was damaged and had been temporarily fixed with tape and there was a hole in one of the ceiling tiles.

In another bathroom, the registered manager told us that the bath and bath hoist were not operational and people only used the toilet. We noted however that the toilet did not fully flush.

We found that the window in one bathroom did not close fully and there was a cold draft coming in, this was of concern, particularly as the bath was situated directly under the window. We viewed in one toilet the flooring was stained and the door was broken.

In one bedroom we observed loose pipework beneath the radiator and bare pipework by the sink which had not been boxed in. We asked the registered manager to explain the conditions, she stated, "It's because new radiators have been put in and the pipework needs boxing in." In two other bedrooms we found some of the tiling was damaged in the ensuite bathrooms and the pipework was exposed.

In others bedrooms we saw that the outside window frames were rotten and the paint was peeling off. We saw windows had been sealed up with sealant and tape. We observed a crack in the window of one window and the window latch was broken which meant the window did not fully close and there was a draft coming in. In another bedroom we saw an area of damaged carpet next to the bed which had been covered with tape, which we concluded was a potential trip hazard.

We observed during our tour of all bedrooms in the home that none of the wardrobes were fixed to the wall to prevent any accidental injuries to people. We spoke to the registered manager about this issue. They said, "We were just talking about this the other day, since a while ago [person's name] pulled a wardrobe down. We asked the registered manager when this accident had occurred. They replied, "a while ago."

We looked around the kitchen area and found that many of the cupboard doors and drawer covers were missing. There was a crack in the glass in the kitchen door which had been taped up. In addition we saw a tap was dripping and one of the water tap handles was missing. The adjourning room next to the kitchen held a number of fridges and freezers. We observed one fridge which was in use was covered in rust, the other fridges and freezers were also rusty in places. We saw water on the floor alongside the fridges and freezers. We were advised that the roof was leaking. A staff member said that the roof kept "lifting off" and the "rain comes in." They stated that the provider was aware of the condition of the kitchen and they were going to get a new kitchen.

In the laundry room we observed that paint was peeling off in places and cavity wall insulation was exposed on one of the walls. There was a lack of shelving and storage space and soiled laundry was lying on the floor.

We viewed outside areas of the home and saw there were empty cardboard boxes, television sets and other rubbish and debris stored next to the main building. In addition, there was a large rubbish bin which was overfilled with rubbish bags and there were three rubbish bags placed next to the rubbish bin.

We observed a fire exit on the first floor. We saw the door had a top sensor and was alarmed. The door opened directly on to a metal staircase which led down to the ground floor. We were concerned that although the door was alarmed, staff might not get to the staircase in time if a person was to access this area and the person could fall down the stairs. We brought our concerns to the attention of the registered manager who advised us that she would deal with the matter as a matter of urgency.

We viewed an electrical installations report which was carried out on 10 March 2014. This stated, "The overall assessment of the installation in terms of its suitability for continued use – unsatisfactory." The report also stated, "An unsatisfactory assessment indicates that dangerous (code 1) and/or potentially dangerous (code 2) conditions have been identified. We asked the registered manager whether remedial work had been carried out. The registered manager stated, "The electrician would have spoken with the provider about this."

This meant that people and others who had access to the premises such as staff and visitors to the home were not

Inadequate

Is the service safe?

fully protected against the risks associated with unsafe or unsuitable premises since not all areas of the home were suitably designed and the provider was failing to ensure that maintenance work is carried out in a timely manner.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We saw a number of urine bottles were in people's rooms and communal bathrooms and were stained and contained debris. There was a strong smell of urine in two of the bedrooms we entered. We asked staff how they cleaned continence equipment such as commode pots. They informed us that equipment was manually cleaned and then soaked in an unused bath [people still used the toilet in this bathroom].

We saw clean towels were stored against the damaged paintwork and no hand washing facilities were available in the laundry room and staff had to wash their hands in a nearby bathroom. We observed clean linen including pillows and duvets was stored on the floor of linen cupboards.

We saw a large number of body sponges stored in the laundry room. Some of these were worn and disintegrating. We asked a member of staff about the use of these sponges. The staff member told us that these were used to wash people, "down below" during personal care.

In a bathroom, we saw on the base of the bath hoist chair a build-up of brown debris. We observed paper towels stored on shelves and window sills, some paper towels were water damaged or dusty. We asked the registered manager why they were not stored in the designated dispensers that were available. She told us that they could not find the key to open the dispensers. A chair with a fabric seat was stored in one bathroom. We noticed the chair was stained.

We observed a waterproof sleeve protector was stored in a shower room. People wore this sleeve to protect any wound dressings or plaster casts they had. We saw that this was dirty and covered in debris. The arm rest of the toilet frame was broken and held together with tape.

We noted no clinical waste bins were present in any of the bathrooms or toilets. The clinical waste bin was stored outside. This meant that staff had to carry clinical waste through the home in order to dispose of it. We noticed that infection control audits were carried out. These however, did not always identify the concerns that we found therefore actions were not put in place.

These issues were putting people who used the service, staff and other people at significant risk of acquiring or transferring infections.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

During this inspection we found medicines were not managed safely and recorded properly.

We looked at 10 people's medicines administration records (MARs). There were a number of gaps in the recording of administration of both oral and topical medicines. We spoke to the registered manager about this issue. She told us that she would address this immediately with staff. This meant that it was not always possible to check whether people had received their medicines as prescribed.

We observed that variable doses of medicines were sometimes not recorded. This meant that it was not possible to carry out an audit to check whether medicines were administered as prescribed since it was not clear whether staff had administered one or two tablets.

We read that one person was prescribed an antibiotic to be taken four times a day for two weeks; however the MAR recorded that the antibiotics had been administered for over three weeks. We spoke to the registered manager about this issue. She told us that the GP had instructed staff to continue administering the antibiotics however this was not recorded.

We examined the management of controlled drugs. Staff used a controlled drugs register to record the receipt, administration and return of any controlled drugs. The register did not accurately record the stock of controlled drugs in the home. The senior care worker told us that most controlled drugs had been returned to the pharmacy, however, the controlled drugs register still recorded that these medicines were in stock.

All care homes must store controlled drugs in line with the Misuse of Drugs (Safe Custody) Regulations 1973. These regulations state that controlled drugs (CDs) must be

Is the service safe?

stored in a CD cupboard which is fixed to a solid wall, or a wall that has a steel plate mounted behind it. We observed controlled drugs were stored in a locked cabinet which was not affixed to the wall.

We observed that medicines audits were carried out. We found however, that these were not comprehensive and did not look at all aspects of medicines management such as the storage of CD's and the recording of medicines.

We found that the service's arrangements for the management of medicines did not protect people. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People we spoke to told us "If I felt unsafe in here, then I would only need to tell my daughter and she would have me out of here." Another said "Yes I am safe in here; I am much safer in here than I was at home, and I had a couple of falls that is why I had to stop living on my own."

We saw a copy of the provider's safeguarding policy. We viewed a safeguarding vulnerable adults poster on the wall in the reception area, which contained contact numbers if anyone had concerns regarding possible abuse.

Staff we spoke to had a good understanding of safeguarding and knew how to report concerns. All of the staff we spoke to reported that they did not have any concerns about the safety of the people living in the home. They told us they felt able to raise concerns and felt the manager would deal with their concerns straightaway. We asked the registered manager if there had been any safeguarding concerns raised. She responded that she had no concerns and would be comfortable to action if necessary. This meant that staff received training and guidance to enable them to raise concerns to the appropriate person

We looked at risk assessments these included the risk of falling, poor nutrition and skin damage. Records showed these had been reviewed consistently. Care plans also identified specific risks relating to each person and detailed the action required to manage the risks. This meant that risk assessments were up to date and therefore staff had access to current information about how to keep people safe.

We saw staff answering call bells and assisting residents in two lounges and others in their private rooms. We asked staff about staffing levels. They told us there was enough care staff to meet people's needs. One care worker told us "We work together as a team and support each other". People who used the service told us, "They do what they can, if there was one or two more then they would be able to speak to us, but there are not enough of them." Another person said, "The girls do their best but they don't have time to sit with you and pass the time of day."

We asked the registered manager about staffing levels. We examined staffing rotas and the registered manager showed us the dependency tool used to calculate the number of staff required. We saw that three care workers were required on the early and late shifts and two care workers on night shift. This meant that there were always sufficient numbers of staff on duty to meet people's needs.

We examined four staff recruitment records for recently recruited staff. We found each record held completed reference checks and a Disclosure and Barring Service (DBS) check dated prior to their start date. DBS checks, replace the Criminal Records Bureau and ISA checks. DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults. This meant the provider had undertaken the necessary checks to ensure staff were suitable to work with vulnerable people.

We examined the Accident and Incident Records. We saw information was collected, including types of incidents and times they occurred. We asked the registered manager if an analysis was carried out to identify any trends or contributory factors which may require investigation. They advised no analysis was carried out. This meant that the home was failing to conduct an analysis of incidents that had resulted in harm to people, in order to improve the care being provided to help keep people safe.

We observed the emergency procedures in place including personal emergency evacuation plans (PEEPS) for people who used the service. We saw it detailed action to be taken in the event of an emergency and was accessible to staff. This meant the provider had suitable plans to keep people safe in an emergency.

Inadequate

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA). They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Although staff understood about supporting people to make choices and decisions they had limited understanding of the MCA and DoLS and how the principles of the legislation applied to people who used the service.

We examined four staff files and consulted the training records; no records were present in relation to training for MCA and/or DoLS. Two care staff we spoke to told us they had not attended MCA training. The deputy manager advised they were attending training in the coming weeks. This meant not all staff had received training and therefore may not be fully aware of their responsibilities under this legislation.

The registered manager told us they had completed one DoLS application with the local authority and were in the process of making further applications. We asked to see documentation relating to the assessments of best interest decisions being taken as none were present in the six care plans we examined. The registered manager advised that verbal consideration had been given whilst the conclusion had not been recorded.

The registered manager told us three people were party to a Lasting power of attorney (LPA), two in regard to health and wellbeing and another for finances. A power of attorney is a person who has been legally appointed to make decisions on the person's behalf when they do not have capacity to make the decisions themselves. There are two types of LPA: Property and Affairs, dealing with your property and finances, and Personal Welfare, dealing with your care. We examined one of the named person's care plan; no LPA documentation was present. We asked the registered manager the location of the documentation they advised it was locked in an office drawer. This meant that there was a risk that relevant people may not be consulted when making decisions as staff were not aware of their legal responsibilities as documents were not clearly accessible.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

We observed a number of people with dementia. We found the environment did not support the needs of people who had dementia. There was no evidence of a dementia programme in place. We asked the registered manager if the home had a designated Dementia Champion, they replied no.

We asked people about mealtimes. One person told us "I like the food most of the time, but if for some reason I don't fancy what is for the dinner then the cook will always do something else, we don't starve." Another told us "I enjoy the food. It is good, plenty of it and always tasty. We can sit where we like but we usually sit in the same place."

During lunch we observed staff assist people to the dining area. The area comprised on three large tables with six places at each table. The area could accommodate 18 people however on the day we visited 22 people lived in the home. As there was only one meal sitting, this meant that there was insufficient space for everyone to sit at the dining area together.

We observed people engaging in chat with each other with limited interaction from staff. People were left unattended for long periods. We saw one person asked another if they need assistance and made comment about the "awful" looking food they had.

A care worker asked what the matter was and said, "Don't you want it" and removed the plate returning with a pudding without any interaction with the person.

We did not observe menu of any sort, photo or written available. We asked the registered manager if choices were available and how people made their choices. The registered manager stated that people were asked earlier that morning and normally a photo menu is located on the wall however it had been removed. We observed a person asked for a cup of tea during lunch they were told they could only have juice at mealtimes. We saw another person ask for a cup of tea following lunch they were told they would have to wait till later.

We spoke to staff about people's nutritional needs. One staff member told us how important it was to make sure people have good nutritious food and plenty of liquids.

Inadequate

Is the service effective?

They said, “It is all important in helping to keep the people we care for well looked after.” They continued to say, “If someone doesn’t want to eat I always encourage them to try a small amount”.

We saw from people’s care plans the full involvement of external medical professionals including Speech and Language Therapists (SALT), community nurses, dietitians and dentists. The registered manager told us about a scheme with Local GPs, were people’s notes were readily available for visiting doctors. We observed on the day of our inspection a stroke nurse visiting and staff requested the return of a district nurse for a person who had initially refused treatment. A staff member told us appointments to external health care professionals were recorded in the daily book.

People told us, “When I was poorly the manager got my GP to come and see me. I was given some antibiotics, the staff gave them to me and my problem was solved.” Another person told us, “Yes, they keep a watch on my weight. I get weighed regularly to make sure I am OK.”

We examined four staff training records and noted all had a record of a completed induction programme. We saw from staff rotas that Health and Safety training had been delivered during December 2014. On the day we inspected we saw off duty staff attend the home to take part in training. The registered manager told us that they had recently secured a trainer to deliver all future training and showed us a programme of training.

Staff told us the training they had had enabled them to do their job and support residents in a more informed way. One staff member said, “We cover a lot of training, I have recently asked for specialist diabetes training which is getting sorted”. Another staff member told us, “The training I have had has helped me to understand what I should do and how I should do it”.

We saw records of supervisions and appraisals held, discussing working practices and training needs. Staff confirmed that appraisals were conducted annually. Staff told us they felt well supported. This meant that staff had received the appropriate training to ensure people are well cared for.

Requires Improvement

Is the service caring?

Our findings

People we spoke to told us they felt that the staff were very caring, kind and compassionate towards them. One person told us, "I did not think I would ever settle in a Home – I was wrong. All the staff are really kind and will do anything you ask". Another said, "The staff, they are all so good and they do care about us. Really nice kind young girls. They never refuse any request just sometimes say they will be back in a few minutes and they do come back."

Relatives of people who lived in the home were also confident the staff team cared for their family members well. One relative who's parent had recently passed away at the home told us, "They cared for him beautifully, in a lovely way" and "They got to know me and how important it was for me to see him looking well presented. He was their primary concern, they cared for all his needs so well. The care was above and beyond".

We noted one person's care plan recorded their preferred method of communication was using a pen and pad. Throughout the duration of the inspection we did not observe any staff member communicate in such a way. However, we did see a visiting professional engage with the person using a pen and pad. We spoke to the professional who confirmed they always use pen and pad to communicate to the person. This meant staff members were not engaging with people in ways in which they preferred.

Staff were busy carrying out daily tasks and we observed varying levels of interaction between staff and people. For example, we saw one staff member take time to sit and chat about home life and what was coming on the television. However, we also witnessed another staff member handing out cups of tea without asking people what they would like or engaging in any conversation. We asked how staff knew what people wanted to drink as they did not ask them. They responded that we know because it's written down. However, we concluded that people may still change their mind and should have been offered a choice.

We observed a person ask if they could go to bed at 10pm. We noted the staff member replied, "No you'll have to go earlier as I'm leaving then". We noted there was no discussion or reassurance around this. We saw the same person asked if they could assist with drying cups up. The staff member responded "No." The person then asked what should they do, the staff member said, "Just wander like you normally do". We spoke to the registered manager about incident; they stated they were shocked by this as it was out of character for the staff member involved. We concluded that staff members did not consistently engage and listen to people and promote them to have opportunities to feel involved in the service.

We observed staff as they did their duties providing care for people. We found that people's privacy and dignity was respected by the staff team. We saw that staff knocked on people's bedroom doors before entering. It was clear that staff knew people well; staff would call a person by their first name. One staff member told us "We know who likes to go to the shops, the local pub, who likes to go along the seafront. If the weather is good enough we try to do it for them."

People told us family members and friends were able to visit them at any time of day. They were welcomed into the home by the staff and offered drinks and biscuits.

One person told us, "Yes our daughter can come at any time and she does come often. The only time to avoid is meal times, even then she would be able to sit and wait till we finished eating." Another person said, "My family get on well with the staff".

Where people had no family or personal representative we saw the home provided information about advocacy services. This was on display on the notice board. Advocates could also act on people's behalf.

Requires Improvement

Is the service responsive?

Our findings

We looked at six people's care plans and saw these contained some personalised information about the person and their preferences. All care plans were comprehensive and covered personal hygiene, washing and bathing; dressing; continence; nutrition; mobility; communication; medication and activities. Full assessments were in place with risk plans to support these. All records we viewed were current and up to date.

The registered manager told us care plans are reviewed monthly and this was confirmed by the records held. We noted when people's needs changed before a review was due, their care records also showed this had been reviewed for any possible changes which may have been required.

The registered manager told us staff were encouraged to read people's care plans and each care worker had a three month rotation of people's care plans so staff knew all people's needs. They also stated staff were kept up to date with daily changes in people's needs as this information was recorded in a communication book and discussed at change overs. This meant staff had access to up to date information about how people should be supported and cared for.

We found people did not receive sufficient engagement or stimulation. People received very little interaction from staff and were unsupervised for long periods. We noted there was a lack of activities. We observed that people sat for long periods of time in the lounge sleeping. The television was on and a chat show was on for most of the morning which people appeared disinterested in. In the afternoon staff organised a ball game and an art activity.

We asked staff whether people were able to access the local community. They told us that this was sometimes difficult due to staffing levels since there needed to be enough staff in the building to look after people.

The registered manager told us a number of people paid for externally arranged activities. We asked people what activities were available. One person told us "We play Bingo and have a sing song." Another told us, "I have a kindle, it keeps me interested. I play games on it." And another person advised us, "It's boring."

We saw the home had a dog which was kept in the conservatory. One staff member said, "The residents love to see the dog and pet it". We did not see this interaction during our visit.

We noted the environment was not dementia friendly; we did not see any reminiscence activities, memory boxes or encouragement by staff to engage in meaningful activity.

We considered that further improvements were required to ensure that people's social needs were met.

We asked people what they would do if they had a concern or complaint about the service they received. People told us, "No I have never had anything to complain about. The staff are very kind and helpful. If I was not satisfied with anything then I would speak to the manager". Another stated, "I would not hesitate to make a complaint if I had one but I never have. I would talk to the manager; she would not accept any wrong doing."

Relatives told us they knew how to complain and would have no hesitation in doing so. They told us they would know if something was upsetting their relative.

We viewed the complaints policy and saw that new staff had signed to confirm they had read and understood the policy. The registered manager advised that one complaint had been made since the last inspection. We saw that it had been investigated and the appropriate action taken.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we identified areas of concern. We examined infection control, health and safety and medicines audits. We found these were not comprehensive and did not highlight the concerns we found. This meant that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

We asked people who lived at the home their thoughts about the service they receive. People told us "Yes, as far as I am concerned it is well managed. The manager could probably do with more staff, but it is up to her." One staff member told us, "I would say we have a good manager. She is always around and we would be able to talk to her about anything we were worried about."

The atmosphere in the home was relaxed and it was noted all staff were supportive of each other and clearly had positive working relationships. Staff told us they enjoyed working at the home. Staff we spoke to told us the registered manager and deputy were approachable and they felt supported in their roles. One staff member said, "The manager is very helpful and I can approach her at any time I need too." And, "We get supported to do our training."

We looked at what the provider did to seek people's views about the quality of the service. We asked the registered manager if the home conducted any surveys or how they ensured people and their relatives were involved in the homes development. They told us client satisfaction surveys were conducted with residents and family, friends and advocates annually. We were unable to view these as the registered manager advised the local commissioning had removed and destroyed them following their visit; they confirmed that they had been conducted. We noted the home had not kept copies of these to refer too.

The registered manager told us that meetings were not held for people who lived there since they had found that these were not well attended. Instead, staff spent time with people regularly on a one to one basis and recorded their opinions. We read extracts of these one to one conversations. One person had commented that they liked living at Parkview, however they were moving to Barbados when they won the lottery! Another person had told staff that they didn't like the quiche.

A third person stated that they would like more cups of tea. We noted it was not always clear what action was taken when issues were raised for example the request for more tea. We observed this person on the afternoon of our inspection asking for more tea and staff asked the person to wait until the tea trolley came around. We concluded that although people's views were sought, there was no clear record available to see if this information had been acted upon.

Staff did not have structured opportunities to share information and give their views about people's care. The provider did not hold regular team meetings. We noted policies indicated that staff meetings were to be held every three to four months and indicated they were compulsory for all staff. We saw two records of meetings held in 2013 but no further meeting records. Staff we spoke to told us they were unable to recall when the last staff meetings were held.

We observed people's sensitive and private information was kept secure in a manned office.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not fully protected against the risks associated with medicines because the provider did not manage medicines appropriately.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider did not have effective systems in place to protect people from the risks of exposure to a health care associated infection.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People's rights against inappropriate restriction of liberty were not protected because appropriate measures were not in place to make the required assessments and applications, in line with MCA and DoLS legislation

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Enforcement actions

People were not fully protected against the risks associated with unsafe or unsuitable premises.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.