Parkview House Care Limited

Parkview House

Inspection report

206-212 Chingford Mount Road
Chingford
London
E4 8JR

Tel: 02085249234
Website: www.parkviewhousecarehome.co.uk

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Parkview House is a care home that provides residential care for older people and people living with dementia. It is registered for 53 people and at the time of this inspection there were 49 people using the service.

This inspection took place on 6, 11, and 12 July 2016 and was unannounced. At the last inspection in December 2014 we found one breach relating to the management of medicines. We found improvements had been made at this inspection.

A manager was in post who was in the process of becoming registered. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had systems in place to ensure the safe management and administration of medicines. We found staff knew how to report concerns or abuse. Risk assessments were carried out and management plans put in place to enable people to receive safe care. There were effective and up to date systems in place to check and maintain the safety of the premises. We found there were enough staff working to meet people's needs.

Staff received support through regular supervisions, appraisals and training opportunities. Appropriate applications for Deprivation of Liberty Safeguards had been applied for and authorised. People had access to healthcare professionals as required to meet their day-to-day health needs.

People were offered a choice of nutritious food and drink. Staff knew the people they were supporting including their preferences to ensure a personalised service was provided. People and their relatives thought staff were caring. Staff respected people's privacy and dignity and enabled people to maintain their independence. A variety of activities were offered which included trips outside of the home. The service dealt with complaints in accordance with their policy and timescales.

The provider held regular meetings for staff and for people and their relatives. People and their relatives were given the opportunity to complete satisfaction surveys. The provider had quality assurance systems in place to identify areas for improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. There were appropriate arrangements in place for the administration of medicines to ensure people received their medicines as prescribed. People and their relatives confirmed the service was safe.

There were enough staff to support people's needs. Relevant recruitment checks were carried out for new staff and criminal record checks were up to date.

People had risk assessments in place to ensure risks were minimised and managed. The provider carried out regular building safety checks. Staff were aware of emergency procedures.

Is the service effective?

Good

The service was effective. Staff received support through training opportunities, supervision and appraisal to enable them to give care effectively.

The provider was knowledgeable about what was required of them to work within the legal framework of the Mental Capacity Act (2005). Staff were knowledgeable about when they needed to get consent.

People were offered a nutritious menu and were given choices of food and drink. Staff were knowledgeable about people's dietary requirements. People had access to support from healthcare professionals as required.

Is the service caring?

Good

The service was caring. People and their relatives told us staff were caring. Staff were knowledgeable about people's needs and life histories.

Staff were knowledgeable about respecting people's privacy and dignity and we observed staff speaking to people in a respectful manner. We saw staff encouraged people's independence. Staff

were knowledgeable about respecting people's privacy and dignity.

Is the service responsive?

Good

The service was responsive. People's care plans were detailed and personalised and were regularly reviewed. Staff were knowledgeable about people's individual needs and preferences.

The service employed activity co-ordinators who organised a variety of activities for people to do including day trips out.

People and their relatives knew how to make a complaint and complaints were dealt with in line with the provider's policy.

Is the service well-led?

Good

The service was well led. The service had a home manager who was in the process of becoming registered with the Care Quality Commission. Staff told us they felt comfortable raising areas of concern with the manager or the deputy manager.

Regular meetings were held with staff to keep them updated on changes within the service. Relatives and people who used the service had regular meetings to enable them to raise issues of concern. The service had a system of obtaining feedback from staff, relatives and people who used the service.

The provider had a system of checking the quality of the service provided and was working to a continuous plan to identify and take action on areas that could be improved.

Parkview House

Detailed findings

Background to this inspection

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

This inspection took place on 6, 11, and 12 July 2016 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience on the first day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. One inspector and a specialist advisor in elderly nursing care visited on the second day and one inspector on the third day.

Before the inspection, we looked at the information we already held about the service including safeguarding and notifications. This included the last inspection report and notifications the provider had sent us.

During the inspection, we spoke with eleven staff including the quality manager, the home manager, the deputy manager, two senior carers, five carers, the assistant cook and an activities co-ordinator. We also spoke to three visiting nurses, four relatives, a visiting friend and eight people who used the service. We observed care and support in communal areas and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We reviewed five care records, four staff files and records relating to the management of the service including, menus, medicines, staff training, complaints and quality assurance.

Good

Is the service safe?

Our findings

At the last inspection we found the service did not have suitable arrangements in place to ensure people consistently received their medicines safely and as prescribed. During this inspection we found medicines were in date, clearly labelled and accounted for. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps in administration records and any reasons for not giving people their medicines were recorded. We saw there were guidelines in place for people who required "pro re nata" (PRN) medicines. PRN medicines are those used as and when needed for specific situations. We saw PRN medicines had been administered and signed for as prescribed.

The provider had a medicines policy which gave clear guidance to staff about the storage and administration of medicines including controlled drugs and monitoring people who self-administer their medicines. Training records showed that medicines were given to people by appropriately trained and competent staff. We observed a senior care staff member administering medicines at lunchtime and saw the correct procedure was used. The staff member checked the expiry date of each medicine, the route it should be given and the amount to be administered.

Medicines were stored appropriately in locked trolleys which were kept in a treatment room. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature and so would be fit for use. We saw weekly and monthly medicine audits were carried out within the home and an audit was carried out by the pharmacy every three to four months. We saw the most recent pharmacy audit done on 19 May 2016 identified several issues. For example, short-life medicines had no opening date which meant they could be past their 'use by date' and the fridge temperature recording was not according to protocol. The issues identified from this audit had been addressed by the time of this inspection.

People and relatives told us they thought the service was safe and there were enough staff. For example two relatives said, "We know [person who used the service] is safe." We reviewed the rotas and saw there were enough staff to meet people's needs. The service had recently introduced a system of floating staff. This meant there was one extra staff member during the day and one during the night whose role was to help out on each unit during their busy times. The service did not use agency or bank staff but used staff from within the team to cover staff absences. This meant people knew the staff supporting them and there was continuity of care. We observed that nobody had to wait long for assistance and call bells were answered promptly.

The service had a recruitment and selection policy. We saw there was a process in place for recruiting staff that ensured relevant checks were carried out before someone was employed. For example, we found staff had produced proof of identification, confirmation of their legal entitlement to work in the UK and had been given written references. We also saw staff had criminal record checks carried out to confirm they were suitable to work with people and there was a system in place to get regular updates.

People had clear risk assessments as part of their care plans regarding their care and support needs. Risk assessments included clear actions for staff to mitigate the risks. For example, people had an assessment for their risk of malnourishment which included monitoring their weight. We saw for one person assessed as being at risk of malnourishment that arrangements had been made for the GP to prescribe supplement drinks.

The home was adequately cleaned and was free from malodour. We observed domestic staff vacuuming the carpets during the inspection. Staff were observed throughout each day to carry out adequate washing of their hands before performing care tasks. We saw the building safety checks had been carried out in accordance with building safety requirements with no issues identified. For example, records showed a gas safety check had been done on 3 December 2015 and portable electrical appliances were tested on 30 October 2015.

Staff were aware of the accidents, incident and fire evacuation procedure, and showed us where the nearest fire escape was. For example, staff told us that if they could not evacuate a resident in the event of a fire, they would move the resident as far away from the fire as possible and close all the fire safety doors to prevent the fire spreading.

Good

Is the service effective?

Our findings

People and their families thought staff had the required skills to give good care. One person told us the, "Staff [were] competent as far as possible." A staff member told us, "Yes, everyone does training all the time." All staff felt that they had enough training to support good quality care. Staff told us refresher training had changed from face to face update sessions to electronic e-learning. One staff member told us they struggled with this issue because, "I am not very good with computers and don't have a laptop," but when asked about this, this member of staff explained they were able to use their daughter's computer.

Training records showed that staff had regular opportunities for training. We saw that staff were required to complete core training such as manual handling, dementia awareness, health and safety, and infection control. The online training matrix was colour coded to show the manager when staff were due to take refresher training or if they were overdue. New staff were required to complete the Care Certificate as part of their induction. The Care Certificate is training in an identified set of standards of care that staff must receive before they begin working with people unsupervised.

The service had a supporting workers policy which gave guidance and included training, supervision and appraisal that staff should expect to receive. This policy had been updated on 30 April 2016. Records showed and staff confirmed they received regular supervision and appraisals. Staff received a general supervision which included discussions about work objectives, working practice, policies and procedures and training. We saw that staff were also given themed supervisions to cover specific topics such as safeguarding adults, privacy and dignity, fluids and nutrition and person-centred working. Staff completed a self-evaluation in preparation for their appraisal meeting and this covered what they had achieved and any difficulties they were having as well as what objectives they wanted to set themselves to achieve in the next twelve months. Records of appraisal meetings included a discussion and agreement of the staff members self-evaluation, the staff member's personal and professional qualities and training requirements.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of inspection, nine people had a DoLS authorisation and the service was awaiting the outcome of a further twelve applications. These applications had been made because the individuals needed a level of supervision that may amount to their deprivation of liberty. For example, some people needed to have a staff member present when accessing the

community to help keep them safe.

Care records contained consent forms which people who had capacity signed in order to give consent. Staff were knowledgeable about the need to obtain consent. For example, one staff member told us, "Ask them and get [consent] in writing and sign it." Another staff member told us, "You have to let them know what you are doing and when," and told us they always asked, "I'm going to do this, is it okay?" We observed during the administration of medicines, the senior care staff ensured residents were happy to take the medication and clearly gained verbal consent.

We observed lunch being served in two of the units. People enjoyed the food and told us, "The food is okay," and "Food is on the whole good." However, two relatives said there was limited choice. We asked one person what they thought about the food and the choice of meals and they said, "We have what we are given." We checked this with the senior carer on duty, and she explained that the residents made a choice from two options in the morning but if the person required anything different, "Then we phone the kitchen and they will send it up." Staff were observed to offer a frequent choice of fluids to people throughout the inspection.

The menus and the assistant chef confirmed that two choices were offered to people for lunch and dinner and people could have a cooked breakfast if they wished. The assistant chef also told us they prepared food in accordance with people's dietary requirements. We saw this information was kept in a file which indicated who required a diabetic, vegetarian, no pork or liquidised meal. We observed the assistant chef spoke to one person who had just begun using the service to find out what their favourite foods were. This person indicated they liked Caribbean food so the assistant chef discussed this with the home manager to arrange incorporating this into the menu plan.

We saw records that people were weighed on a monthly basis. These were up to date and where there were concerns, people were weighed more often and appropriate referrals were made to the dietician. The care staff were also questioned on what they would do if a resident had lost their appetite or was losing weight , they said they would let the senior know and they would tell them when they should weight the resident and what to do.

Care records confirmed that people were able to access support from healthcare professionals when needed and referrals were made in a timely manner. For example, care records showed people had visits from the district nurses, the GP and rapid response nurses and the outcome of these visits were documented.

Good

Is the service caring?

Our findings

People and their relatives thought staff were caring and looked after people well. For example, two relatives told us the service provided, "Really good care." One person told us, "The staff are kind, lovely people, would not want to be anywhere else." Another person said, "I'm looked after very well" and "The staff are absolutely lovely." A third person said, "Staff are very nice and helpful."

We observed staff speaking to people in a polite, respectful and caring manner. For example, staff spoke gently to one person receiving end-of-life care who was unconscious as they carried out care tasks. We saw that staff took the time to listen to people and showed an interest in what people were speaking about. Staff sat with people encouraging conversation and sharing laughter. We observed some people had a nap in their chair after lunch and staff ensured they were covered with a blanket.

Staff were knowledgeable about people's personal histories and their current care needs. One staff member told us they went with the deputy manager to assess people in their home before they began using the service. This staff member told us, "To get an idea of their needs. Some will visit for lunch or tea. Some come for a respite week, [for a trial stay]. If they come early, you can introduce them to the other residents." Another staff member said, "We get to know them by talking to them and develop the relationship day by day." A third member of staff told us, "Build up a positive rapport. Have a laugh with them, say hello and ask everyone individually how they are. This builds up the trust."

The service had a "keyworker" system. A keyworker is a staff member who is responsible for overseeing the care a person received, ensuring they have enough toiletries and clothing and liaising with other professionals or representatives involved in the person's life.

Staff were knowledgeable about respecting people's privacy and dignity. For example, one staff member said, "Always knock, always keep the door closed when dressing them." Another staff member told us, "When giving personal care we keep the doors closed. If they want to talk to you in private, you go to their room." A third member of staff said, "Shut the door. Knock on the door before entering and wait for them to say 'come in'." We observed staff knocked before entering people's rooms or bathrooms and referred to people who used the service by their preferred name. People had a picture of themselves on their bedroom door which helped them to find their room.

Staff gave examples of how they enabled people to maintain their independence. One staff member told us one person who used the service liked to clean and was able to take part in washing dishes after a meal or sweep the floor if they wanted to help. Other staff told us, "Encourage them to do things for themselves. You can be there with them in case they need help" and, "We are only there to assist. They might like to wash their own face or they might like to clean their own teeth."

We observed staff encouraged people's independence. For example, staff were seen encouraging those who could walk with a zimmer frame to do so, and one person was independently mobile in his wheelchair. There was a calm, relaxed atmosphere throughout the home.

Good

Is the service responsive?

Our findings

We asked staff if they understood what personalised care was. One staff member told us, "Look at the whole person [when giving care] and we have a chit-chat at the same time." Another staff member said, "To know the individual needs, how they get dressed, what time they go to bed, what they want on the TV. I know some of my ladies like tennis so I put the tennis on. We've started to put questionnaires into the care plans which the residents enjoy." A third staff member told us personalised care was, "Specific needs and wants of one person." Staff also told us they had enough time to give people personalised care.

Care plans were comprehensive and personalised. Assessments were completed before a person began using the service to ensure their needs could be met. Records included people's likes and dislikes. For example, each person had a personal care preference plan which included how they liked their personal care to be delivered, the time they like to get up in the morning and their preferred bedtime routine. People also had a personal preference plan for food and drink which included dietary requirements, favourite foods and what assistance they needed with eating and drinking.

People's care records contained their life history and indicated what their end of life wishes were. Care records contained an activity care plan which stated the activities the person enjoyed participating in and included conversation topics. People's care plans were reviewed regularly by the senior staff and updated as required. A senior staff member told us when an individual had a change in needs they documented this in the care plan and verbally told the staff. We saw the service was in the process of making further improvements to care records to make them more person-centred.

The service employed two activity co-ordinators and there was a board near the entrance door showing the two month programme of activities on offer. We spoke with one of the activity co-ordinators who told us a hairdresser visited the service each Tuesday and on one or two Mondays each month came in to do hair perming as required. Activities offered included dominoes, indoor bowls, nail painting, bingo and flower arranging. One to one activities were offered to people who preferred not to take part in groups.

The activity co-ordinator told us domestic staff helped with group community trips when extra staff were needed. We saw from the activity programme that people could have massage sessions or participate in a knitting club, a book club, watching films, Tai Chi or armchair exercises. People were able to help look after the garden in good weather and the service had arranged for visiting dogs. The activity co-ordinator told us that occasional activities were also arranged. For example the service had ordered and looked after caterpillars so people could watch them transform into butterflies.

People and their relatives told us they knew how to make a complaint. The service had a comprehensive complaints policy. We reviewed the complaints records and saw eight complaints had been made since May 2015. The provider's analysis of these complaints indicated how many complaints covered laundry, finance administration, catering, management and care. For example, we saw a written complaint was made on 25 April 2016 relating to a person's respite stay in the home. This was acknowledged on 29 April 2016 and responded to on the 24 May 2016 with a resolution which was within the provider's policy.

We also reviewed three compliments received in the service during May 2016. For example, a relative had written a thank you letter which included the statement, "The staff who have been so caring and supported both my [relatives] so wonderfully during their time with you in your home." Another relative had sent a card saying, "It really helped us to know that [person] was in such good hands and so well cared for in every way – we cannot thank you all enough." A third relative had written to a named staff member, "Thank you so much for everything you have done. You truly are one in a million."

Good

Is the service well-led?

Our findings

The service had recently employed a new home manager who was in the process of becoming registered with the Care Quality Commission. Staff told us they would approach the manager or deputy manager if they had any concerns. One staff member told us, "If you need something, can go and ask the manager."

Staff confirmed and records showed there were regular staff meetings. We reviewed the most recent general staff meeting held on 18 May 2016 and saw the topics discussed included training, care plans and knowing the needs of people using the service. We also reviewed the staff unit meetings held during June 2016 and saw the topics discussed included keyworking, medicines and skincare. Staff told us they found these meetings useful.

The service held meetings every eight weeks for relatives. The deputy manager told us there had not been one recently due to the service being without a manager and the new manager only starting recently. We reviewed the minutes of the most recent meeting held on 4 March 2016. The manager at the time opened the meeting with, "Don't forget everyone this meeting is for all of you so please give me your opinions and tell me if you are not happy with anything." We saw people's responses were noted and included, "I am very happy here. I have many friends here and we laugh all the time."

The provider had systems of obtaining feedback from staff, relatives and people who used the service. We saw feedback questionnaires had been sent to relatives in December 2015 and 17 had been returned completed. The analysis of the questionnaires showed that 32% of those returned thought the service was excellent, 52% thought the service was good, 10% thought the service was average and 6% thought the service was poor. The quality manager told us they planned to discuss the outcome of the feedback questionnaires with the new manager so they could address the areas of dissatisfaction.

The service had an auditing system to check the quality of service provided. We reviewed the food safety audit carried out on 21 January 2016 and the care plan audit carried out on 31 January 2016 and saw no actions of improvement had been identified. The service had a system of monthly checks which included a nutritional audit that identified people who needed referring to a dietician and a tissue viability audit that included identifying people who required the input of a tissue viability nurse.

The provider had asked a specialist advisor to carry out a review of the service on 16 May 2016. The specialist advisor had made some recommendations, for example, to review the handover documentation and to include the person's weight and mattress setting on the forms used for checking mattresses. This had been addressed at the time of this inspection.

The service was working to an action plan, written by the quality manager, to help the home to continuously improve the quality of care provided and was reviewed monthly. We saw this document identified who was responsible for completing the action, when the action needed to be completed and the person responsible signed and dated the action when completed. For example, one action was for the service to source and provide training for the home's activities co-ordinator specifically relating to activities for people living with

dementia. We saw this action was for the home manager to complete by the end of May 2016. The quality manager explained this had not yet been completed due to the manager commencing employment recently and this would be one of the tasks they would be asked to complete.