RCH Care Homes Limited

Park View Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Park View Care Centre is a residential nursing home providing personal and nursing care for to up to 88 people. The service provides support to a range of people including frail and elderly, people with various nursing needs and people living with dementia. At the time of our inspection there were 79 people using the service.

Park View Care Centre accommodates 88 people across four units. Two units on the ground floor are predominantly for people living with dementia and two units on the first floor are for people with nursing needs.

People's experience of using this service and what we found
We found a risk relating to the correct use of PPE that was not being managed safely. We raised this with the provider who took action.
Some risks were not being managed as safely as possible, such as around fluid charts or one person's weight loss. This was raised with the provider and actions were taken.

People were receiving their medicine when they needed them, but we found paperwork for end of life medicines was missing. The provider took action to put this right.

One relative and some staff said that there could be times when people have to wait for their call bells to be answered. We have made a recommendation about how call bells are audited.

Governance systems had been improved and were in the process of being embedded in to practice. Some issues we found with care plans had not been identified by the provider but they were working towards reviewing all people's care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us they felt safe at the service. One person said, "I am very happy here. They look after me well."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (06 October 2021)
The provider completed an action plan after the last inspection to show what they would do and by when to improve.
At this inspection we found some improvements had been made and the provider was no longer in breach

of regulations relating to safeguarding people from abuse and staffing. We found the provider remained in breach of regulations relating to safe care and good governance.

This service has been in Special Measures since 06 October 2021. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified continued breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Park View Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors on the first day and one inspector on the second day.

Service and service type
Park View Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Park View Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post, but the manager was in the process of applying to register with CQC.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, including local commissioners, and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection-
We spoke with six people who used the service and three relatives about their experience of the care provided. We spoke with 10 members of staff including the regional manager, manager, deputy manager, three nurses, one senior carer and three care workers. We reviewed a range of records. This included four people's care records and associated risk assessments. We looked at three staff files in relation to recruitment records. A variety of records relating to the management of the service, including audits and meeting minutes were reviewed.

After the inspection –
We reviewed audits and care records and spoke with four staff.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question Inadequate. At this inspection the rating has changed to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a risk that people could be harmed.

Assessing risk, safety monitoring and management, and using medicines safely

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found some improvements had been made, but some areas still required improvements and the breach remains.

● Not all risks had been safely managed. One person had a treatment that was classed as an aerosol generating procedure (AGP). AGP's produce tiny droplets in the air. Government guidance requires staff working with people with AGP's to have FFP3 masks that protect them from very fine particles. The manager told us staff had not been trained how to use FFP3 masks, so had not been using them. When the person tested Covid positive the manager had tried to arrange a trainer to come to the service. However, this was not possible for some days and staff were left exposed to the risk of Covid infection. We raised this with the manager who amended the current risk assessment and chased up training for FFP3 masks.
● Some people needed their fluid intake monitored for health reasons. However, we found that three people we reviewed did not have their fluid charts monitored, or shortfalls in fluid intake followed up. One person had drunk less than half their recommended daily allowance for two weeks. When we asked the nurse on duty what action had been taken the nurse was not able to show us any follow up. This left people at risk of dehydration.
● One person was at risk of malnutrition due to a medical condition. Nurses had been monitoring the persons weight and recording it on a special screening tool that recorded weights and identified risks around malnutrition. However, the latest weights had been recorded on a separate book and staff had not noted there was a significant weight loss from the previous month. We raised this with the manager who referred the person to their dietician and also ensured that staff were spoken with about completing care records correctly.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. We have reported on the lack of FFP3 protection for people using aerosol generating procedures.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

The failure to robustly assess the risks relating to the health safety and welfare of people is a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
People were free to have visitors. Some restrictions were imposed on specific parts of the building during active outbreaks of Covid-19. However, essential care givers were still able to visit and the use of testing and temperature checks mitigated this risk.
● At our last inspection in 2021 we raised concerns about a lack of PRN [as required] protocols. At this inspection we reviewed peoples medicines records and found that PRN medicines prescribed. Where people had these medicines prescribed there were PRN protocols to set out how these medicines should be used.

● Other risks had been managed safely, such as fire risks. Other issues we had highlighted at the previous inspection, such as concerns with the support people need when distressed had been reviewed, assessed and mitigated safely.
● At our last inspection we found concerns with falls and the management of behaviours that may challenge others. At this inspection we saw that these risks were being managed safely. Falls were being recorded and monitored for any trends, and staff were able to speak confidently about how they manage people's behaviours.
● People's medicines were being managed and administered safely and in line with best practice guidelines. Regular checks of medicines were made and people were able to receive their medicines in the way they needed, including liquid medicines.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse, and learning lessons when things go wrong

At our last inspection the provider had failed follow current legislation and guidance in lawful seclusion and restraint and had failed to ensure systems and processes were operated effectively to prevent abuse of people. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were being kept safe from the risk of abuse. There was an overview of safeguarding in the front of each person's daily files, that covered different types of abuse and who to report any concerns to.

● At our last inspection we found concerns with restrictive practices, such as seclusion, and staff did not have a good understanding of safeguarding people. However, during this inspection staff we spoke with confirmed they had training and knew how to report concerns. People we spoke with told us they felt safe living at Park View Care Centre. One person told us, "10 out of 10 for the staff and the feeling of security they give. Staff are reliable and they've helped me so much."

● There was a safeguarding log where any incidents were tracked and any lessons that had been learned were shared with the staff team. Learning had been shared effectively when there were incidents.

● There had been incident analysis conducted by the provider to identify trends and themes and reduce the risk of further incidents. We spoke with the manager who told us of different learning points that had been shared with staff following reviews of accidents and incidents.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18. However, we have made a recommendation about auditing call bells.

● Since the last inspection the manager had accurately used the dependency tool to determine how many staff were required. When resident numbers were reduced, staffing levels stayed the same. Staff competencies and training had improved and staff told us that there were enough staff to keep people safe.

● We received mixed feedback about response times to call bells. One relative told us there can be long delays some days, and some staff also said that when staff have called sick it can be a struggle to answer call bells in good time due to the workload. However, people we spoke with told us they didn't have to wait long. One person said, "On times when [staff] are hard pressed they ask if it's an emergency and ask if I can wait; but generally, it's as consistent as I wish." Another person told us, "I sometimes have to wait 5 minutes but not a long time."

● We spoke with the manager about the mixed feedback we received for call bells. The manager had not previously been made aware of an issue with call bells and had been doing spot checks of response times by pressing bells and waiting for staff to respond.

We recommend the provider considers a formal audit of call bell response times.

● During our inspection there were suitable numbers of skilled and qualified staff on duty to meet people's needs and keep them safe. We reviewed staffing rotas and where shortfalls in staffing had been identified agency staff had been booked to work.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Inadequate. At this inspection the rating has changed to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

At our last inspection the provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and maintain accurate and contemporaneous records of people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- During our last inspection we found concerns with behavioural support, safeguarding, falls management, constipation, infection control, staffing and governance. At this inspection we found improvements had been made in relation to falls management, behavioural support, safeguarding and staffing. However, we found some concerns remained with infection control, the safe management of some risks and governance. Two of the four previous breaches of regulation we found had been met whilst two breaches remained.
- We asked the manager why audits had not been effective in picking up the issues we found. The manager told us that audits currently had been done on a 'dip test selection of care plans', and they were working hard to look at all people's care plans. The provider and manager had been working with trained nurses and senior care staff to gradually check on people's plans and notes. Despite the work done to make improvements there was a need for further improvements to continue, and for the new governance systems to be embedded in to practice.
- Some care records still contained inconsistencies. For example, one person with a health condition that meant they required a special diet did not have this information on their overview of care sheet. The overview of care sheet is one-page document that would be used by new or agency staff to get to know the person.

The failure to assess, monitor and improve the quality and safety of the service; and mitigate the risks relating to the health, safety and welfare of people is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a registered manager but they were no longer in post. The manager in day to day charge of the service was in the process of registering with CQC. The manager understood when to make statutory notifications to CQC and had ensured these were sent when required.
- Since our last inspection the provider drew up a home development plan to address the issues we found.

An external consultant was also bought in to work through improvements that were needed. The provider and manager worked with the consultant, senior management team and staff to looked at breaches identified at the last inspection and put them right.

● We saw that a lot of progress had been made, such as an effective falls analysis with a monthly assessment of any trends. There were weekly clinical governance meeting where clinical issues were discussed with staff and managers to drive improvements. The manager had also introduced daily flash meetings and regular team meetings for staff. The manager was confident that the reporting structure and culture in the service was much improved and we saw evidence that improvements had been made.

● The manager was receiving support from the registered provider. In addition to consultants there were also visits from senior managers who had input in the house development plan. The manager told us they had support in place when they were unable to be at the service, such as on days off. The manager said, "We share risk [information] between the deputy manager and me. [The deputy manager] knows what to look out for; I've just been off for 4 days and I have no concerns."

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

● We saw progress had been made around changing the culture of the service. Staff were more confident in reporting incidents and following up safeguarding issues. Staff were also more confident in raising issues with the manager. One staff told us, "We've been doing really good with all the changes. [Manager] is lovely, she is very supportive towards us."

● The service employed a large number of Nepalese staff and the provider had printed flash cards with pointers in English and Nepalese about how to support and respond to people living with dementia. We saw cards that covered areas such as, how to respond to someone asking to see a relative who has passed away or a range of activities to occupy people at different times of day. These helped all staff to display the values of the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Where things went wrong the manager and the staff at Park View Care Centre had been open and transparent with families. We saw where letters had been sent to a family following an incident explaining what had happened.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People were being involved in the service. One person told us, "I attended residents meetings a couple of times; activities as well. I keep in touch regularly with what's going on here through [social media page]."

● The manager was engaging staff in looking at different ways of working. There have been regular staff meetings and any that were cancelled (for example due to Covid pressures) were replaced by a letter update to staff. Staff requested a whole service rota as it was easier for them, so the manager implemented this.

● Staff were supervised by an external consultant who gave fedback that senior managers sometimes did not speak often with staff. This was actioned and we saw senior managers conversing with staff.

Working in partnership with others

● The manager and provider had been working effectively with partner agencies. Local authority commissioners had been involved in improvement plans for the service. The service had been working closely with social services, local health teams and community health professionals.

● Information was being shared securely and safely. Where necessary information was sent using unique identifiers instead of people's names and staff were aware of confidentiality.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to robustly assess the risks relating to the health safety and welfare of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess, monitor and improve the quality and safety of the service; and mitigate the risks relating to the health, safety and welfare of people.