Viewpark Care Home Limited

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Inspection report

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Date of inspection visit: 23 and 29 June 2015
Date of publication: 29/10/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
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 23 and 29 June 2015. The first day was unannounced, which means that the service did not know we were coming on that day.

The previous inspection had taken place on 2 and 4 April 2014, when we found breaches of two regulations made under the Health and Social Care Act 2008. These related to failure to report a safeguarding incident, and several defects in the premises. We received an action plan stating that these issues had already been rectified. At this inspection we found improvements had been made to meet the relevant regulations.

Viewpark Care Home ('Viewpark') is a purpose built care home registered to provide care and support to 27 older people. There were 25 people living in the home on the day of our inspection. The accommodation is on two floors, with two lifts and two staircases. There is a large and a small dining room, two lounges, and a conservatory. The home is situated in a residential area of Moston in north Manchester.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

We learnt during this inspection that the staff had a good understanding of safeguarding vulnerable adults and would report any suspicion of abuse appropriately. Medicines were stored safely except that the cabinet for storing controlled drugs did not meet legal requirements. This was a breach of the Regulation relating to the proper and safe management of medicines.

Senior staff were trained in the administration of medicines. We noted that staff were not always observing people who were given medicines constantly to ensure they had been consumed.

We saw that recommendations in relation to the safety of the building made in our last report had been implemented. We observed that the top of one staircase was accessible and suggested that the risk should be monitored. Necessary safety checks were being carried out and there were procedures to assist evacuation in case of an emergency.

Staffing levels were acceptable. Eight staff had been recruited within the previous year to cover vacancies. In response to concerns which had been expressed about the proposed reduction of staff cover at night the registered manager was providing an additional member of staff at the start and end of each night shift.

We checked and saw that safe recruitment procedures were followed for new recruits. New staff were undertaking the new Care Certificate, a new qualification for care staff. All staff were keeping their training up to date and there was a system of supervisions and appraisals. However we saw that sometimes supervision was used to communicate messages to staff rather than as an opportunity for staff to raise issues themselves.

Not all staff had been trained in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager had obtained an authorisation under DoLS but had not notified the CQC. This was a breach of Registration Regulations.

Forms were used to obtain consent but sometimes had been signed by a relative, which is not the correct process.

People told us they liked the food. The home was receiving advice on nutrition from dieticians and people's weights were monitored. The cook was proactive in improving people's enjoyment of food.

Residents had regular access to healthcare professionals, and District Nurses visited the home daily. The service worked well in partnership with local hospitals and health providers.

Residents and their relatives gave for the most part positive feedback about the caring atmosphere within the home. People's dignity was maintained by staff.

We observed a lack of confidentiality in that paperwork was left accessible in an area accessible to residents and their visitors. We were told these were documents awaiting filing. We saw some personal details were available to view in the file in the hallway intended for emergency services. These two examples of a failure to maintain confidentiality were a breach of the Regulation relating to good governance.

Viewpark was signed up to an end of life programme and cared for people nearing the end of life in a dignified and compassionate way.

We found that care files were not properly maintained. Documents were difficult to find, some were blank and some were contradictory. We found that the registered manager and staff did not have an in-depth understanding of person-centred care. This was a breach of the Regulation relating to person-centred care.

People who wished to be involved enjoyed activities at Viewpark. A new activities organiser was about to start. Meetings took place for residents and relatives, and the registered manager had an open door policy so that relatives could raise issues with her whenever they wished. There had been one formal complaint in the previous 12 months which had been responded to by the provider.

Staff and relatives gave positive feedback about the leadership ability of the registered manager. There had been a high turnover of staff but the registered manager was hoping for greater stability in the staff team.

Summary of findings

The registered manager had not notified CQC of all safeguarding incidents and serious injuries which had occurred in the home in line with their statutory obligations. This was a breach of the relevant Registration Regulation.

The registered manager carried out a programme of audits. We considered that the care file audits needed to be more systematic and thorough. The medication audits had not identified the problem with the Controlled Drugs cabinet. The lack of effective systems for auditing of care files and medication records was a breach of the Regulation relating to good governance.

The registered manager and the deputy carried out regular spot checks at night which helped ensure that people were safely supported during the night.

In relation to the breaches of Regulations mentioned above you can see what action we told the provider to take at the end 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?

Requires Improvement

The service was not safe in all respects.

Staff had a good understanding of how to protect vulnerable adults from abuse. Medicines were administered safely but the cabinet for storing Controlled Drugs was unsuitable.

The building was well maintained but we noticed a risk with one accessible staircase.

There were adequate staffing levels and safe recruitment processes.

Is the service effective?

Requires Improvement

The service was not effective in all respects.

Staff were receiving adequate training but supervision did not always match their needs.

The registered manager was aware of the Mental Capacity Act 2005 and had obtained an authorisation under DoLS but had not notified the CQC.

The food was good and the service received support from a dietician programme.

Is the service caring?

Requires Improvement

The service was not caring in all respects.

Residents and relatives gave positive feedback about the care given by staff.

We observed a lack of confidentiality in relation to documents and personal information about people.

The service was part of an end of life programme designed to improve the dignity and comfort of people nearing the end of their lives.

Is the service responsive?

Requires Improvement

The service was not responsive in all respects.

Care files were disorganised and poorly reviewed. The understanding of person-centred care needed development.

There were activities available for those willing and able to take part.

Meetings took place for residents and relatives, and the registered manager had an open door policy. There had been only one formal complaint in the previous 12 months which had been responded to.

Is the service well-led?

Requires Improvement

The service was not well led in all respects.

Summary of findings

Relatives and staff praised the registered manager's leadership. There had been a high turnover of staff which affected staff morale.

The registered manager had not notified the CQC about some safeguarding incidents and serious injuries.

There was a system of internal audits but the audits relating to care files and medication needed to be more thorough.

Viewpark Care Home Limited

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 23 June and 29 June 2015. The first day was unannounced. On the second day we returned by arrangement.

Two Adult Social Care Inspectors carried out this inspection on both days.

Before the inspection we reviewed the information we held about the service. This included notifications from the service of events they were required to inform us about, and information received from other sources including Manchester City Council about the service. The service had submitted a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the contract officer of Manchester City Council for information about the council's recent monitoring visits.

During the inspection we spoke with four people who were living at Viewpark, five relatives and five members of staff. We spoke with the registered manager, the deputy manager and a senior care assistant, and with a person doing work experience.

We conducted an observation known as a SOFI (Short Observational Framework for Inspection). This is a method of observing people and the care they are receiving, to help us understand the experience of people who may have difficulty communicating with us.

We reviewed a range of records about people's care and how the home was managed. These included five care files, staff training and supervision records, three staff personnel records and quality assurance audits which the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

We were not able to communicate effectively with all the people living in the home, but those who were able to answer our questions told us they felt safe and were well looked after. No one we spoke with raised any concerns about how the staff treated them. They told us that if they had any kind of problem they could raise it with the registered manager and they felt confident that it would be dealt with. One person said if they had any kind of problem they could speak to the "lady in charge." Another person told us, "Yes I feel safe and comfortable here."

Staff told us they had received safeguarding training and this was confirmed by information we saw on the record of training received. Staff had a good understanding of the different types of abuse that might occur in the home, and described the action they would take to keep people safe from harm. They said they would report any concerns to the registered manager immediately. One member of staff said that they hadn't witnessed anything that concerned them while working at Viewpark. They added, "If I did see anything I don't agree with, I would report it to the manager or the deputy manager." They felt confident the registered manager would investigate thoroughly and deal with the issue. Another member of staff understood the term 'whistleblowing' and said they would report any suspected abuse by a colleague immediately.

We knew from our records that many safeguarding incidents had been reported appropriately to both the local authority and the CQC. Appropriate disciplinary action had been taken in the case of one care worker. This showed that action was taken to keep people safe from harm.

We looked at the ordering, storage and administration of medicines to determine whether they were safe.

We saw that the large cupboard in which medicines were stored was kept locked except when it was in use. There was a fridge and we saw records showing that the temperature was being monitored. Controlled drugs were stored in a special cabinet. Controlled drugs by their nature are required to be kept more securely than others. The cabinet used was made of plastic and was not attached to any wall. This meant it did not conform to the regulations regarding the storage of controlled drugs, namely the Misuse of Drugs (Safe Custody) Regulations 1973. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(g) which relates to the proper and safe management of medicines. We mentioned this breach to the registered manager who said she would take action to install a proper controlled drugs cabinet as soon as possible.

We checked a sample of controlled drugs to verify that the balance of medicines recorded in the controlled drugs record book matched the amounts in the cabinet. We found the records were correct, except in one case. On the Medicines Administration Record (MAR) for the previous evening one administration of a controlled drug had not been recorded. The member of staff who was showing us the record stated that this was their oversight and that they definitely had administered the dose the previous evening at 9pm. We saw that the administration was indeed recorded in the controlled drugs book. They then signed the MAR in our presence. This was not good practice as such records should not be amended after the event. It is very important that accurate, reliable and contemporaneous records are kept of administration of medicines, in case of any query by medical professionals. We reported this to the registered manager.

The same member of staff explained to us that medicines were always checked in by two members of staff. We saw evidence of this. They added that the senior care workers, who were the only staff who administered medication, knew when medicines were due and about specific instructions when medicines were required, for example, to be delivered an hour before food. These instructions were on the MARs which were supplied by the pharmacy.

We found that the senior care staff had completed medication training. This meant that staff had been assessed as competent to assist people living in the home with the day to day administration of their medicines. The registered manager told us that no-one was currently receiving medicine covertly, which means without their knowledge. She added that there had been no medication errors reported within the past year. However, we had witnessed one error ourselves, regarding the failure to record on the MAR a controlled drug being administered. This reduced our confidence in the claim that there had been no errors within the last year.

At about 9.15am we observed two residents were sitting at a table in the dining room having breakfast, with tablets in

Is the service safe?

front of them on the table. Staff were not constantly observing them. The registered manager later explained to us that the staff would always check that the medicine had been taken. She added that these were people who could physically take their own medicines, usually without prompting, and staff would observe them from a distance. We pointed out that unless staff were constantly observing there was a risk that people might not take their medicines or that another person might consume them accidentally.

A system was in place to record accidents and incidents, such as falls. The registered manager told us that the outcomes of accidents and incidents were analysed to see what lessons could be learnt and reduce future risk by taking preventative action. In our previous inspection we noted some potential hazards in the building. We received an action plan stating that these had already been rectified. On this inspection we checked to see whether this was the case and that the action taken meant those areas were now safe. In one detail we found that the action was not sufficient. At the inspection in April 2014 we had found that the door on the cupboard housing the lift machinery had no lock and was falling open. At this inspection we found that a lock had been installed but it was flimsy and there was a small risk it could be pulled open allowing access to the electrical machinery. There was also no lock on the boiler cupboard. We drew this to the attention of the registered manager. In other respects the necessary action following our previous report had been taken.

The environment inside the building downstairs was safe for people to move around. We were told that the flooring of the downstairs corridors and communal areas was due to be replaced with non-slip laminate flooring. The registered manager told us she was in the process of getting quotes for this to be done. Upstairs we saw that there was a pressure mat outside one person's bedroom door. It was explained to us that this was intended to alert staff if the resident left their bedroom, and assistance would be provided as the person had mobility difficulties. This was therefore intended to improve safety. We noticed however that the mat itself was bumpy and the wires attached to it were a potential trip hazard. We mentioned this to the registered manager who explained why the pressure mat was in place and said she would check its safety.

One of the staircases was out of sight of staff as it was not in the main area of the building, but the top of the staircase was accessible to people in several bedrooms. Staff told us that people did not use the staircase, but used the lift instead. However, we witnessed one resident who was independently mobile come out of their bedroom and move towards the top of the stairs apparently intending to use them. The member of staff who was showing us round gently guided them to the lift. They explained that the home did not want to limit access to the top of the staircase as that might constitute a fire hazard. However the registered manager should monitor the residents who live in that part of the home and ensure that the risk of people using that staircase is controlled.

Outside in the garden area there was a partially flagged path going around the building. On the first day of the inspection we noticed that it was uneven in places and would not be safe for wheelchair users or other people unsure of their footing. The registered manager told us that work had been commissioned to repair the path. On the second day of our visit we saw this work had been done and the flagstones had been re-laid. This made it safer for people to use. There was still one section of grass which people needed to cross to get from one section of path to the other which made it difficult for people with reduced mobility to move around the garden safely.

We saw records of maintenance and checks of the building, including fire safety certificates, records of fire drills and maintenance of the fire alarm system and fire extinguishers. A risk assessment had been undertaken within the last 12 months and a full service of the system was undertaken on 11 March 2015. There had been a visit from the Greater Manchester Fire and Rescue service and minor recommendations had been implemented. This meant that the building was protected to the best level available against the risks of fire.

We saw that there was a 'Viewpark fire file' kept on a table in the hallway for easy access in case of an emergency. There was a summary at the front which listed the residents and their mobility issues. Further back were individual PEEPS (Personal Emergency Evacuation Plans) which gave more details about each individual and their need for assistance in the event of evacuation. This would allow firefighters immediate access to the information they needed.

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We also saw records relating to gas safety, the electrical installation, and regular testing of hoists and the lift. The plumbing system had been tested for legionella. These records were all up to date and showed that the provider was actively ensuring the safety of the building.

An infection control audit had been undertaken in October 2014 by a specialist from the council. A number of recommendations had been made. We saw that Viewpark had implemented a significant recommendation by installing new equipment in the sluice room. Personal protective equipment (disposable gloves and aprons) was available for staff. This indicated that the provider was aware of the need to prevent infection from spreading and protect people's health.

One relative had said in answer to a survey, "They could do with more staff." Another relative told us they had witnessed occasions when a resident had needed assistance but no staff were immediately available. One visitor gave an example of a Saturday afternoon when they thought there had been only three staff on duty. They did not specify the day so we were unable to verify this. This visitor stated: "Staff come over really well there just isn't enough of them."

We asked the registered manager about staffing levels. She told us that agency staff were never used. Two bank staff were available. There were one senior care worker and three care workers on duty on the Tuesday morning we arrived. We were told this was the usual number between 8am and 2pm, except that on Mondays and Thursdays there was an extra care worker in order to assist the district nurses during their regular visits. This showed flexibility in the deployment of staff. There were also one senior care worker and three care workers during the afternoon shifts from 2 to 8pm. We saw copies of the staff rotas for the end of June and the whole of July which confirmed these staffing levels, and staff also told us that this was the case.

The night shifts were covered by three staff on three nights a week, and two staff for the other four nights. The registered manager told us that their plan was to reduce the level to two staff each night, but to have one member of staff do a longer shift from 2 to 11pm, to cover the period in which people were going to bed, and have another member of staff start at 5am and work to 11am, to cover the busy morning period.

We saw minutes of a staff meeting on 12 March 2015 where one senior member of staff had expressed reservations about the reduction in numbers of staff at night to two. It was recorded they expressed, "Concerns about two being on at night has staff struggling." This would cause problems for example if two staff were needed to give personal care to one resident, and at the same time another resident needed support. We noticed in the minutes of a senior staff meeting on 16 June 2015 that the provider had refused the suggestion of having another member of staff on night duty each night of the week.

The CQC does not stipulate specific ratios of staff to residents, because the number depends on many variables including in particular the dependency needs of residents. We found evidence that staff themselves thought that three staff were needed at night. We acknowledged that the registered manager had partially addressed this issue by arranging to have a third member of staff until 11pm and from 5am. Provided the situation is carefully monitored we considered that this remained within the scope of the Regulation related to deployment of sufficient numbers of staff.

We became aware that some staff were working double shifts, and some staff were working multiple shifts in a week. The registered manager told us that some staff specifically requested to work 12 hour shifts from 8am to 8pm, three days a week, because they preferred that to working on more days. We saw that at least one member of staff was working those three days and also picking up additional shifts. It was important for the registered manager to ensure that no staff were working excess hours beyond their capability.

Eight new staff had been recruited within the previous year. We looked at three staff personnel files and saw that the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. We noticed that Viewpark's standard application form did not request job applicants to account for any gaps in their employment record; it would be better practice to request that information. There was evidence of a DBS check (Disclosure and Barring Service check for any convictions or cautions). There were documents proving the job applicant's identity, and two references had been obtained. One applicant had named a senior member of staff at Viewpark as their referee, and a reference had been obtained. We raised the

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question with the registered manager whether this had been appropriate, as the senior member of staff was not independent. We were satisfied by the explanation given and that the service used safe recruitment practices.

Requires Improvement

Is the service effective?

Our findings

We obtained a copy of the training matrix which recorded training undertaken by all staff. We saw that all staff had undertaken recent training in the core subjects of moving and handling, infection control, food hygiene, health and safety, and fire training. All staff had also taken a session in Six Steps (an end of life programme which assists care homes to support people nearing the end of life), in challenging behaviour and in confidentiality. Some staff had undergone training in other subjects relevant to their job role, for example first aid, continence training and safeguarding. The cook stated that they had completed a basic food hygiene course in the past, and that last year they completed a 3 month 'Nutrition for Older People' course with Bradford College, which the provider had paid for.

We saw on personnel files evidence that new staff had followed a programme of induction, as well as two weeks shadowing experienced staff. The registered manager told us that the service had now decided new staff would embark on the Care Certificate, a new scheme introduced in 2014 which was designed to teach 15 core standards over a 12 week period. As a result the service had dispensed with the previous induction programme, although the registered manager told us that they were still doing a practical moving and handling session with new care workers.

Undertaking the Care Certificate meant that new staff would receive a sound basic knowledge of their role, which they would supplement with the training provided for all staff on a regular basis.

We saw evidence that staff received regular supervision and appraisals. The registered manager told us she had conducted 10 supervision sessions the day before our first inspection visit. She told us that usually the deputy manager would run supervision for the junior care staff, roughly every six to eight weeks, while she herself ran supervision for the senior staff. We saw from records that on some occasions the registered manager used the whole supervision to get a particular message across to staff individually. For example there had been an issue earlier in the year over an apparent breach of confidentiality. We saw a pre-typed supervision form on which the registered manager had written the message she wanted to communicate to staff. At the top it said "Copy to be given to supervised staff" which meant that all staff would receive an identical record of their supervision. Supervisions should be used to allow staff to raise their own issues about workload, training needs and matters relevant to them. We learnt that team meetings were classed as supervisions, which would lengthen the interval between one-to-one supervision sessions. One member of staff did tell us that they found supervision helpful and that they had discussed aspects of their own work.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which form part of the Mental Capacity Act 2005 (MCA). They are intended to protect the rights of people who lack the capacity to make their own choices about their care. Under the legislation a provider must issue an 'urgent authorisation' when they believe they may be depriving someone using the service of their liberty. At the same time they must apply for a 'standard authorisation', to a supervisory body, in this case Manchester City Council.

We saw from the training matrix that a minority of staff had received relevant training in this area. Two staff had attended 'DoLS mental health training' in April 2015, and 6 other staff had attended training on the MCA between April and June 2015. This was out of a total of around 18 care staff. It would be better practice to ensure that all care staff had a basic understanding of the MCA and its significance in care homes.

We discussed the legislation with the registered manager. She told us she had received advice that staff at the home could not carry out mental capacity assessments, which would be the first stage in determining whether or not someone had capacity to consent to a restriction of their liberty. We informed her that this was not the case. Although a formal mental capacity assessment would be conducted by a trained professional, there was nothing to stop Viewpark carrying out its own initial assessments. By the second day of our inspection the registered manager had started doing mental capacity assessments.

Providers are required under registration regulations to notify the CQC of any request to a supervisory body for a standard authorisation under DoLS, once the outcome of that request is known or if it is withdrawn. We had not received a statutory notification about any DoLS application since the previous inspection, or indeed at any point since the provider's registration in 2010. However, in the PIR the registered manager stated that there was one

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DoLS authorisation in place. The registered manager told us that there had previously been three authorisations made for one resident. She added that these had now "run out" because the resident was less mobile, was on a new medication regime and was no longer showing signs of wanting to leave the building. We checked this person's care file thoroughly and there was no paperwork relating to DoLS applications. The registered manager showed us a copy of the application for a standard authorisation stored on the computer, dated 21 October 2014. There was no copy of an urgent authorisation. The application was made on the basis that the resident had already left the home on one occasion and was still trying to leave the home regularly. There was no record to show whether this application had been granted but the registered manager told us it had been. The failure to report this at the time was a breach of Regulation 18(4B) of the Care Quality Commission (Registration) Regulations 2009.

The registered manager said that applications for DoLS authorisations had been made in respect of two other people, one of whom who was no longer living in Viewpark. Their file was therefore not available. However, the record keeping at Viewpark did not enable a clear assessment as to whether DoLS applications had been made when needed, and made correctly.

We saw on files that consent forms were used to seek consent for such things as using the person's photograph, and for administering medication. We saw in one file that the resident's daughter had signed the consent forms. It was not clear that this was regarded as legitimate consent or merely to show that the relative had been consulted. We discussed with the registered manager the fact that a relative cannot legally give consent on someone's behalf. If the person is assessed as lacking capacity to make a particular decision, then there needs to be a best interest meeting to determine that person's decision. A relative can be consulted and informed, but cannot make decisions unless appointed as a power of attorney. A power of attorney is someone formally appointed to look after someone's welfare or financial decisions.

We asked residents about the food at Viewpark. One person told us: "Lunch is quite good. Yes we get a choice." Another person said they liked the food provided, that there were often choices available, and that they could ask for an alternative if they wanted. A third person said: "There's plenty to eat and drink." This was confirmed by staff who said there was always a minimum of two choices. At lunch there was plenty of food available. However, one regular visitor said that sometimes they arrived to find their relative's food beside them uneaten, because they needed assistance and, they suggested, staff had either not realised this or had forgotten them. We were not sure whether this suggestion was the only explanation for the food being left. This visitor said, "I think the food is good here and looks appetising" and added, "The other residents say they like it."

Viewpark was signed up to Tamsin, a nutrition support service in North Manchester which provides advice and support around healthy nutrition. The aim of the scheme is to support care homes to be able to recognise and treat malnutrition and to improve the standard of nutritional care. Two members of staff had been signed up as 'Tamsin champions' and undergone training, and a third was in training. Dieticians and other staff from Tamsin came into the home each month, to observe meal times and make recommendations, give advice for residents with eating issues and to prescribe nutritional supplements. Recommendations they had made included that napkins should be available, residents should have a drink 30 minutes prior to the meal and then be offered another hot or cold drink during the meal, residents should be encouraged to finish their meals, and food should be presented in smaller pieces to help residents eat as much as they can.

We spoke with the cook who told us that these recommendations had been taken on board. The cook met with Tamsin staff who gave advice about specific residents' dietary needs. The cook said there was a four week meal rota, but that they would alter it based on feedback from residents. When we asked about the quality of the meals at the home, the cook stated, "I cook the same food I cook for my family."

Record of nutrition and hydration were kept for people where there was any reason for concern. Residents had their weight checked regularly, and risk assessments were in place if weights should fall. If this happened, residents had three day nutrition assessments completed to ensure they were provided with the correct supplements to their daily dietary needs. We confirmed on care files that weight had been recorded weekly up until the Tamsin programme started, and it was now being recorded monthly on the Tamsin files. The cook told us that the care staff informed

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her when a resident was losing weight so that she could fortify their meals. The cook stated that the residents were offered a fruit smoothie each afternoon and most really seemed to enjoy them. This was confirmed by one relative who said: "The staff make mum fresh fruit smoothies and she really enjoys them."

The cook told us that there were currently no residents with cultural or religious food requirements or special diets, although they had experience of preparing halal foods and would know how to cater for those with other requirements.

We saw on care files that people had regular access to healthcare professionals to look after their health needs. Records were kept of visiting professionals including the district nursing team, the nursing home team, GPs and chiropodists. The registered manager told us that most residents were registered with GPs from the same medical practice; people were very happy with the service they received and GPs attended promptly when requested. Staff would sometimes accompany residents to hospital, especially if there was no family member available to do so.

We saw a letter from January 2015 on one care file from a Speech and Language Therapist (SALT) which expressed concern about a breakdown in communication regarding the resident's need for thickened fluids or a soft diet when they were discharged from hospital. The SALT stated in the letter that the resident might have been at risk of aspiration. This indicated a need to ensure that instructions from health professionals were followed closely.

One visitor told us that her relative's toenails needed cutting more frequently than other people, however they often had to ask for a podiatrist to be arranged. The visitor felt staff should have made the arrangement as they should surely notice when they assisted their relative to bathe and dress. On another person's file the podiatry record had not been signed since July 2014, although the care plan stated that the podiatrist should visit regularly.

Requires Improvement

Is the service caring?

Our findings

We spoke with people who lived in the home and their relatives, and asked them about the relationships between staff and residents. One resident told us they were happy in Viewpark, and added: "They care for us, we get our meals, the staff are very nice and friendly." Another person said: "Staff will do anything to help," and added staff were "Great to talk to and easy-going." A third person stated her opinion that, "The staff are genuinely caring and try to talk to all the residents. The staff do an excellent job with the residents with dementia," adding "Staff are supportive and encouraging at mealtimes."

However, one person did state: "Staff ignore me most of the time." But added that she wouldn't complain to the manager because, "They're all the same." During our observations we did not see staff ignoring people.

In one response to a customer satisfaction survey a relative had written: "All staff are caring and kind. The manager is always about to chat to." Another person had written, "My aunty loves Viewpark." One relative stated to us: "I think they care for her much better than I could."

One visitor told us that their relative had favourite care staff and found some of the others abrupt. Two of their 'favourite' long serving care staff had left within the past year and the visitor felt that their relative had not yet bonded with the newer staff. Nevertheless, this relative said: "I have no concerns or worries about the care provided here." Another relative, who told us they had complained about certain aspects of the home, said of the staff: "In general the staff are fine – they are caring and they mean well."

However, another visitor stated that on two occasions they had arrived to find that their relative did not have their teeth in, and was not wearing glasses or hearing aids. On other occasions they appeared unkempt with stained clothing and their hair in disarray. The visitor said when that happened: "I'm upset as I know how she'd feel if she could see herself." This suggested a lack of attention had been paid to maintaining this person's dignity. We discussed this person's needs with the registered manager. She said that this person had a hearing problem, but was often unwilling to keep their hearing aids in. She added they could lip read well and that the best way to communicate was to ensure you were close enough to them for them to do this. We pointed out that this was not documented in the person's care plan and that it was not satisfactory to assume that "All the care staff know this."

One member of staff we spoke with said: "I care and I love every single one of the residents." One resident told us that they thought that staff respected the privacy and dignity of themselves and other residents. A relative said that staff directed questions at the resident (rather than at the relative) and in their opinion staff respected the resident's privacy and promoted their dignity.

We saw that bedroom doors had name plates on and photographs of the person whose bedroom it was. This would help people to identify their bedrooms. This was an improvement on the previous inspection in April 2014 when we had commented that the names of residents were typed on pieces of paper, and there was no photograph on the door. Research in dementia care has shown that people often are better able to recognise older photographs of themselves, for example a wedding photograph, than a contemporary one. We saw one bedroom door without a photograph on. Staff told us and the person confirmed that this was their choice as they preferred a photograph not to be used. This was an example of the service respecting people's individual choices and their autonomy.

We became aware of one resident who spent most of the time in their room. A member of staff told us that the resident's family had requested that they should spend more time downstairs in the communal areas, which is where they were when we arrived. The member of staff said: "We tell them a fib and say that we are cleaning the room, so that they will go downstairs for a while." This might be seen as disrespectful but was done to improve this person's quality of life and reduce social isolation. While we were with the registered manager in her office she took a phone call from a health professional about one resident and said "She's like a little whippet." This could be construed as disrespectful, even though it was not addressed to the person concerned. These incidents showed there were occasions when people were not treated with complete respect.

In two respects we were concerned about a lack of confidentiality. On the first day of our inspection there was a pile of documents on top of the filing cabinet in the conservatory, a room adjoining the main lounge. This was an area in which staff sat to complete paperwork, and held

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handover meetings. The pile of documents included some documents of a confidential nature relating to deceased residents and pages of care records. The registered manager told us that these papers were awaiting filing. However, they were open to view in an area that was used by residents and their visitors. By the second day of our inspection most of this paperwork had been put away, but not all of it. It was mentioned earlier that the 'Viewpark fire file' was kept on a table in the hallway for easy access in case of an emergency. This meant it could be easily opened and read by any visitors to the home. While the information about mobility was vital in case of an emergency, we noticed that some of the entries in the summary on the front page of the file were demeaning and disrespectful. For example next to one person's name was written "Becomes agitated and will scream." Another entry stated "Can be argumentative and will refuse to move." Since the file was in a public area these entries betrayed a lack of respect and confidentiality towards the residents. We discussed this with the registered manager at the end of the inspection who agreed to revise the entries on the file, to maintain residents' dignity but still remain informative for the emergency services.

These two examples of a failure to maintain confidentiality were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to Regulation 17(2)(c).

As we were being shown around the building we heard one person in their bedroom who was crying. A member of staff told us that this person had severe arthritis and often cried out in pain. They asked the person whether they had received their pain killers that morning, which they had done. The member of staff was sympathetic. We checked that person's care plan to see whether their condition was being monitored, and found it was.

During our observation in the lounge before lunch we saw that staff were coming and going. They did not have any interaction with those people who were dozing. One person was engaged in drawing and staff stopped to ask how it was going and to admire it. When it was time for lunch, staff approached people calmly, explained that it was lunchtime and asked if it was okay to move them to the dining room, and gave the appropriate assistance. This was done in a calm unhurried manner.

The home had qualified for a Six Steps award in October 2014. The Six Steps is an end of life programme, in the North West, designed to enable care homes to improve end of life care. Nine members of staff had received training on end of life care in March 2015. We saw that appropriate paperwork was present when relevant in people's files, intended to help avoid unnecessary pain and suffering in the last days or hours before death. We noticed that one of these forms, a 'DNACPR' form which instructs the staff and paramedics not to attempt CPR (Cardiopulmonary resuscitation), had not been fully completed by the relevant GP. It did not give the likely cause of death. There was a potential risk this might make it invalid if the paramedics arrived. We mentioned this to the registered manager. At the date of the PIR five residents had a DNACPR form in place.

In other respects those who were identified as being at end of life (defined as being likely to die within 12 months) were treated appropriately. They were placed on a palliative care register. Where necessary a Statement of Intent was signed. This is a document which allows a GP to predict that death is likely within the next 14 days. The home's policy, stated in the PIR, was that 'no resident will go into hospital unless deemed they need to. They will be allowed to end their days within the home as they have wished to.' We knew from our records that in many cases people passed away in the home, with family and care staff present. This usually allowed a more dignified and comfortable death than in hospital.

Requires Improvement

Is the service responsive?

Our findings

We looked at five care files in detail to assess how well the staff at Viewpark were delivering person-centred care. One aspect of person-centred care is to build up a detailed history of people's past lives, in order to enable staff to develop meaningful relationships with them and understand what and who is important to them and how they want to be supported. Care files had an 'All about me' section in which information about the person's history, family and preferences was recorded, enabling care staff to build rapport with the person concerned.

We found that the care files were disorganised and poorly maintained. For example, on one file there was more than one care plan index, making it difficult to locate documents. There were two different risk assessments, following a fall in May 2015. There was also contradictory information. In the 'All about me' section it stated that the person had vascular dementia. But on the next page under the heading 'Mental Health – do I have dementia?' it stated "No". This was confusing and demonstrated a lack of attention, especially as the file had been reviewed. Another heading was 'Do I require assistance with incontinence?'; the answer given was "No", but we observed during our visit that this person did require assistance with continence needs. This meant the person was at risk of not receiving care they needed because the information on the care file was inaccurate.

On another person's file was the record of a hospital visit stating, "Went for Xray on hip." But there was no date given. This could be significant in the event of later query. On the same file the daily reports were jumbled which made it difficult to look at the person's recent history. On another file the person's first name was spelt inconsistently all the way through, which suggested a lack of respect for their individuality.

On a fourth person's care file there were a number of documents which were blank or incomplete. There was a sheet for staff to sign to demonstrate awareness of that person's care needs, but no-one had signed it. The question "Do I have dementia?" was blank. There were different weight charts in two sections and it was difficult to know which was the most recent. The record of hospital visits was blank, although we knew from this person's relative that they did have visits to hospital. This all meant that the person's care needs were not being properly documented.

We brought these matters to the attention of the registered manager. By the second day of our visit the first file had been reordered and revised; obsolete documents had been removed and archived, and the file was much more presentable. Nevertheless, this particular file was representative of others we looked at and demonstrated a poor attempt to assess and record needs and preferences, meet people's needs, and enable health professionals to understand the care and treatment being provided. If care plans are poor then staff are less likely to be well informed and able to meet people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to Regulation 9(3)(a)(b) and (c).

The care plans each had a column headed "Review date", which showed that they were reviewed each month. Some of the monthly reviews had identical wording which suggested a lack of attention. We learnt that Viewpark had a keyworker system whereby each resident was allocated to a specific care worker who was responsible for maintaining and updating their care plan. However, we witnessed a senior care worker updating care plans for a number of people whose keyworkers worked on the night shift. They explained they were doing it because the night shifts were often too busy. While this was commendable teamwork, it negated the purpose of having keyworkers, which was that they would each be responsible for a few residents.

We asked the registered manager what their understanding of person-centred care was. She replied that it was when staff have knowledge of people. That is important, but there is a great deal more to it than that. Person-centred care is tailored to the individual needs of each person, recognises their particular strengths and needs, and offers them compassion, dignity and respect.

We asked people living in Viewpark and their relatives about what activities were available. One person told us they enjoyed helping out at mealtimes by collecting up plates and helping to tidy up. They stated they did not like

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to spend a lot of time downstairs or doing activities with other residents, but had seen other residents knitting. They added that Christmas had been, "Great, we sang carols and there was entertainment."

Another person said they did not like to get involved in activities, preferring to spend time alone. They were happy to sit, and could do so without getting bored. They added that they liked to sit outside and smoke cigarettes in the smoking shelter, and they could come out whenever they wanted. Another person said there were sing-songs daily but they did not like them or get involved as they sang the same songs all the time, and were noisy. They added: "I like going into the garden when it's really nice out, and enjoy getting my hair done." Hairdressing took place in the 'Groovy Chicks Salon'. We heard that people enjoyed visiting the salon and this helped them take pride in their appearance.

Two visitors, who told us they came on the same day every week, said that they had never before witnessed a sing song and chair exercise session as had occurred that day, the second day of our inspection. That suggested that the activities were for the benefit of the inspectors.

On one person's file there was an activities chart which had nothing recorded since August 2014.There was no activities co-ordinator at the time of the inspection, the last one having left a month earlier. The registered manager informed us that a new one had been appointed, a former care worker who knew the residents well. In the meantime there had been regular entertainments, including film nights and bingo. We asked whether there were any trips out and were told there were not, because the residents did not want to go. We considered it likely that not all people would want to go on such trips, but that some might.

One relative told us that they had never been invited to a relatives' meeting and had never received a survey or questionnaire about the home. However, we saw the results of customer satisfaction surveys. Another relative told us that they had attended a meeting the previous winter. There had only been one other relative there, but they had found the meeting useful. We saw minutes of this meeting which had taken place on 29 January 2015. Because there were only two attendees the registered manager had discussed their specific issues with them. The registered manager stated that because she had an open door policy and relatives could come in and discuss things with her at any time, she felt there was less need to hold regular meetings. This was confirmed in the minutes of an earlier residents' meeting on 3 October 2014 which stated "So far no relatives have come asking for a relatives' meeting." We learnt however that families had requested a photoboard of staff. It would enable visitors and some residents to recognise staff. This was put up in the entrance hall between our visits. This showed that the service was responding to people's wishes.

There were also minutes of residents' meetings every three months. This offered those residents who were willing and able to participate a chance to comment on the care they were receiving. The minutes in February 2015 recorded that, "All the residents are happy with the meals they are offered and the choices available."

Information about how to make a complaint was in the entrance hall. The registered manager stated in the PIR, and confirmed during the inspection, that the service had received no written or formal complaints within the previous 12 months. She stated in the PIR: "We have received no complaints therefore we within our home are providing a good service to all our residents." However, one relative informed us that they had made a complaint in February 2015. They had sent an email direct to the provider and we saw an exchange of correspondence. The relative told us they had met with the provider to discuss the complaint but had not been satisfied with the outcome. The registered manager told us she had not considered this complaint when completing the PIR because it had been dealt with by the provider. But it had been a complaint about various aspects of care provision. We did see that the provider had taken the complaint seriously even if the complainant remained dissatisfied with the response.

Requires Improvement

Is the service well-led?

Our findings

We received positive feedback from staff about the registered manager and senior staff. A member of staff said to us: "I feel managers live and breathe this place. We work together brilliantly as a team." Another member of staff said: "I wouldn't be frightened to put my mother in here if she needed it."

One relative told us the registered manager was always approachable, and added that any minor issues they had raised informally with the manager had been dealt with to their satisfaction. Another relative had written in a customer satisfaction survey: "If management are not here senior staff will support and can contact management." Although some relatives whom we met during our inspection expressed concerns about various aspects of the care delivered, as outlined earlier in this report, none of them expressed any reservations about the registered manager or senior members of staff.

We saw minutes of recent staff meetings and senior staff meetings from which it was clear that staff felt comfortable raising issues about the running of the home. This indicated that the registered manager was open to criticism and saw the advantage of allowing staff to contribute ideas. We observed a handover between morning and afternoon staff and saw this was an effective means for staff to communicate any changes in people's needs.

We had received concerns, prior to the inspection, about staff turnover and staff morale. We asked the registered manager about this who told us that eight members of staff had left within the last year, and there had been eight new recruits, which was a high turnover relative to the number of care staff (18). One relative commented, "I don't know who the staff are." The registered manager told us she was hoping for greater stability, which would enable the staff to work better as a team and support each other to deliver high quality care.

The registered manager told us that she felt well supported by the provider and that funds were made available for necessary one-off improvements such as the outside paving and the planned new flooring. But we also learnt that the provider was less willing to accommodate requests or suggestions for ongoing costs such as an extra member of staff at night.

The service is subject to registration requirements to report notifiable events to the CQC. These include serious injuries, deaths and safeguarding events. On reading care files we came across some events which had not been reported to us. One was a safeguarding incident in March 2015 when there was an argument between two residents over a pair of glasses and one had pushed the other. This incident was reported to families and to the local authority, and the registered manager wrote a protection plan (a plan designed to protect the victim from the same incident recurring). We also saw on one care file an incident report from September 2014 when one resident had caused red marks and scratches to another resident's neck. A third incident between two residents in January 2015 had been reported to the local authority safeguarding team, but not to CQC. As incidents involving possible abuse, they ought to have been reported to CQC.

There were also a number of serious injuries (for example, broken bones) which had not been reported. We discussed these with the registered manager. In one case she showed us the completed form which she said she had submitted. Unfortunately the CQC reference number was incorrect, which meant it could not be assigned to the right service. In two other cases broken hips had not been reported to the CQC. In one case the registered manager told us the injury had occurred while she had been on leave. However in a well led organisation responsibility for notifying the CQC should have been delegated to another member of staff in her absence. At the least the injury could have been notified upon her return.

It is important that we are notified of all such incidents so that we can monitor events within a service and take action where necessary. Failure to submit the notifications was a breach of Regulation 18(2)(a) and 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

We asked the registered manager about the system of audits, or checks done to monitor the quality of the service. They showed us a 'Viewpark monthly audit' dated 30 November 2014 but nothing more recent.

The registered manager told us she audited three care plans every month. She checked that care plan reviews had been done, that indexes were used correctly and up to date. We looked at the audits of the last three months, which recorded the initials of the residents whose files she had looked at. The only comment made was "All fine, no issues." Two out of the three files looked at were identical

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in May and April 2015, and one of those had been looked at in March as well. This was not an effective audit as there was no checklist of questions or areas looked at. There was also no record made on the files themselves to show they had been audited, which may be the reason why two of them were audited in consecutive months. Given the issues we identified with care files, in particular the disorganised state of one of them (described in the preceding section of this report), there was scope for developing a more rigorous system of auditing care files.

There was a medication audit every month and we saw the latest completed one. It involved checking the MAR sheets to verify that administration of medicines was recorded correctly. There was a pre-printed set of questions, one of which asked: "Does the Controlled Drugs cabinet comply with legislative requirements?" As already set out in this report, the cabinet manifestly did not comply with those requirements and this had not been picked up in any medication audit. The pharmacy that supplied Viewpark had done its own audit and produced a report dated 15 May 2015. This report made two recommendations which had been implemented.

We found that the lack of effective systems for auditing of care files and medication was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to Regulation 17(2)(a) and (b).

As well as the infection control audit carried out by Manchester City Council in October 2014, we saw on the file multiple copies of an internal infection control audit which were all blank, and some completed ones. There were also reports of a 'walkround', which involved identifying jobs on the building. These reports included checks on the hoists, wheelchairs and other equipment. There was no longer a maintenance person working for Viewpark, but the registered manager called in tradesmen when needed. She said this was more effective.

The registered manager and deputy manager conducted unannounced night spot checks roughly every two months at different times of the night. They said this was intended to support night staff and encourage them, but it also provided a means of ensuring they were awake and busy. This demonstrated good personal commitment on the part of the registered manager and her deputy.

The registered manager told us in the PIR that she had a good relationship with local health bodies and with commissioners, and that they often recommended Viewpark as a good placement. She also told us that urgent admissions could sometimes generate problems, and gave an example. We saw that staff had good relationships with District Nurses and followed their advice in relation to aspects of care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The Controlled Drugs cabinet was not made of the right material and was not affixed to a solid wall: Regulation 12(2)(g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered manager had not reported the outcome of DoLS applications made under the Mental Capacity Act 2005: Regulation 18(4B)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Confidential information about people was not being kept securely: Regulation 17(2)(c)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care files were disorganised and did not ensure people's needs could be understood:** **Regulation 9(3)(a)(b)(c)**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered manager had failed to submit notification of three allegations of abuse: Regulation 18(2)(e) and of several serious injuries Regulation 18(2)(a)
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There was not an effective system of audit of care files and medication: Regulation 17(2)(a) and (b)