Jewelglen Limited

Parkview Nursing and Residential Home

Inspection report

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Ratings

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

Overall summary

We carried out an unannounced inspection of Parkview Nursing and Residential Home on 14 April 2015. We last inspected this service on 19 September 2014 when we found the service was meeting the standards in all outcome areas inspected.

Parkview is a large property built on three levels. The home provides accommodation and personal care for up to 32 people. At the time of our visit there were 31 people living at Parkview. The home which has garden areas to the front and rear is situated close to Bolton town centre and is on main bus routes.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are

Summary of findings

'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 found breaches of six regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safe care and treatment, staffing, safeguarding, need for consent, dignity and respect and good governance. You can see what action we told the provider to take at the back of the full version of this report.

We had concerns about how the service ensured people were safe. The environment was run-down and areas of the home were unclean. This posed a risk to people in relation infection prevention and control. Not everyone felt staffing levels were sufficient and we saw that shifts were not always covered when a staff member was absent. Not all staff were able to demonstrate a good understanding of safeguarding procedures

The service did not manage risk well. We were told one person was constantly supervised by staff in order to prevent them from falling but found this was not the case. The service had also failed to take action to manage a fire risk that had been highlighted during a recent fire safety inspection.

Medicines were not always administered using safe procedures. We also saw that cream medicines were not being kept safely as they were kept loose in people's rooms.

The service told us all staff training was up to date. However, they were unable to provide any record of what training or supervision had been undertaken at the time of the inspection. Information on training received following the inspection showed some training had been undertaken. However, there was no evidence that safeguarding training was up to date for all staff, and there was no evidence of training in areas including the Mental Capacity Act, Dementia and behaviours that challenge services. We had concerns about staff competence to effectively support people who could present behaviours that challenged the service.

Staff did not always seek people's consent in accordance with the Mental Capacity Act 2005. We observed staff on a number of occasions turning people's chairs to face the other way without asking them, or informing them what they were doing. Staff understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards was limited.

Most people told us they liked the food on offer. We spoke with kitchen staff who told us they were starting to try new dishes to create a new menu.

Some people we spoke with did not think all staff were kind and caring. We observed interaction between staff and people to be limited and requests for support were not always acknowledged.

The service had installed CCTV, which covered areas including the communal lounge. People's privacy and choice in this matter was not respected as the service had not regularly consulted people and the CCTV monitor faced out into the entrance lobby.

There were no arranged activities and there was little stimulation for people living at Parkview. Staff told us they did not always have time to arrange activities when they were short staffed.

There were resident and relatives' meetings held around once or twice per year. Other than these meetings there was little evidence of the service seeking feedback from people. The registered manager told us people weren't really interested in care plans, however, one relative and one visitor we spoke with told us they would have liked to have been involved in the process and were not.

Staff told us they would offer people choices such as around clothing and bed-times. However, some people felt their choices were limited in this area. We also found people's choice had been restricted in relation to choosing when to watch the television in the main lounge.

Audits were carried out by the registered manager but did not cover all aspects of the service provided. This meant that areas where we identified concerns such as in relation to infection control and the environment had not been identified as areas where action was required.

Some staff felt well supported and thought the service was well-led. However, other staff raised concerns that they were not treated fairly or listened to. There was no evidence of recent staff meetings or other ways having been considered to involve staff in developing the service.

Summary of findings

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

We had concerns relating to infection prevention and control. Areas of the home were unclean including communal areas and bathrooms. Urine was seen on a toilet floor, which was not cleared promptly.

We found the service had been short staffed. This meant people had had to wait to receive support such as to use the toilet. On the day of our inspection staff were not always present to provide the support people required.

The service had not managed risk effectively. We observed one person who lived at Parkview providing support to another person to walk when there were no staff present. This person was identified as being at high risk of falling and the registered manager had told us staff constantly supervised them.

Is the service effective?

Inadequate

The service was not effective.

Staff did not always seek consent from people before providing them with support. On several occasions we observed staff pull people's chairs round when they were seated at tables without asking first or communicating in any way.

The provider did not keep an up to date record of training undertaken by staff. Information we received following the inspection indicated there were gaps in training such as safeguarding. We had concerns in relation to staff competence in coping effectively with behaviours that could challenge.

There were few adaptations to make the environment more accessible to people living with dementia. Some people had photos on their bedroom doors, however these were very small.

Is the service caring?

Inadequate

The service was not caring.

Some people living at Parkview and their relatives did not feel staff were always kind and caring. We saw interaction between staff and people was often limited.

The service had installed CCTV which covered areas including the communal lounge and garden. The service could not demonstrate that they consulted people about its presence since it was installed. The monitor screen also faced into the entrance lobby so would have been visible to any person entering the home.

Summary of findings

Some people's rooms did not contain many clothes. A relative had made a complaint that clothing was not hung up, and a staff member told us items often got mixed up and went to the wrong person.

Is the service responsive?

Requires improvement 

Not all aspects of the service were responsive.

We did not observe any organised activities on the day of our visit. There were not regularly organised activities and some people told us there was nothing to do.

The registered manager told us people were not really interested in care plans. However, one relative told us they had offered to help develop their family member's care plan and been told it was done already. Another person told us they would like to have been involved in care planning but had not been given the opportunity.

The registered manager told us resident and relatives meetings took place once to twice per year. We saw feedback forms and questionnaires had been completed by people living at Parkview.

Is the service well-led?

Inadequate 

The service was not well-led.

There was a registered manager in post as is a condition of Parkview's registration with CQC. The registered manager also provided care and support to people living at Parkside throughout the day.

Although some audits were carried out, these did not include areas where we had identified concerns such as infection control, the environment or staff training and supervision.

Whilst some staff felt well supported and thought the service was well-led, others felt they were not always treated fairly. There was no evidence of any recent staff meetings or other involvement of staff in developing the service.

Parkview Nursing and Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 14 April 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included notifications that the service is required to inform us about safeguarding, deaths and other significant events. The inspection was brought forward from the date it had been originally scheduled due to information of concern that was shared with us. For this reason we had not requested a provider information return, in which we ask the provider to give us certain information about the service prior to inspection.

During the inspection we looked at all areas of the home including people's bedrooms, the kitchen, bathrooms, the laundry and communal areas such as the dining room and lounge. We observed the mid-day meal and spent time observing in the lounge. We spoke with eight staff. This included the registered manager, two carers, two kitchen staff, a senior carer, a domestic and a laundry worker.

We spoke with seven people who were living at Parkview and three of their relatives who were visiting on the day of the inspection. As not everyone living at Parkview was able to tell us about their experiences living there, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care and support to help us understand the experience of people who could not talk with us.

We reviewed records related to the care and support of people. This included six care files and five medication administration records (MARs). We also looked at other documents kept in relation to the running of a care home including two staff personnel files, service/maintenance records and audits. We could not find any records of resident or relatives meetings and so asked the provider to send these records to us by the following day. These documents were received as expected.

Inadequate

Is the service safe?

Our findings

We found areas of Parkview that were unclean and presented a risk to people in relation to infection prevention and control. There was a staircase leading to the second floor of the home and we saw that there were several spillages in this area, which were not cleaned at any point during the day. Many of the toilets, baths and bathrooms that were accessible to people were dirty and there were stains on the floors and on the toilets. One of the baths we saw had a dirty cushion from a wheelchair and tissue paper in it. Another bathroom contained personal hygiene products including a bar of soap, flannel and towel.

There was a smell of urine that was present in both communal areas and some people's bedrooms. Carpets and arm chairs in the main lounge area were badly stained, were dirty and were in need of replacement. We also saw stains on the wallpaper and what appeared to be old food and drink on the walls and floor in two of the bedrooms we looked at. At approximately 11am, we observed urine on the floor in the downstairs toilet, which was still present at 4pm when we checked again. This was despite two members of domestic staff working at the home during the inspection. One person living at Parkview owned a dog and we saw there was a large amount of dog faeces on part of the lawn in the garden. The garden area was in frequent use by people living at Parkview throughout the day of our inspection. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment.

The registered manager told us the standard staffing levels were four care staff in the day and two care staff on the night shift. If the registered manager was working in the day they were included as one of the four care staff. We saw domestic staff were used to provide extra support to people over meal-times. The registered manager said staffing levels were not worked out formally, but that they used a job allocation list that would highlight if there were not enough staff to cover duties. Two staff had recently left, but the registered manager said there was no difficulty covering shifts within the remaining staff team. We looked at rotas for the six weeks prior to our visit and saw there had been 10 occasions when staffing had been reduced to three care staff in the day.

Three of the staff we spoke with said they didn't think there were always enough staff. They said this could impact people as they might have to wait to be supported to use the toilet. A visitor we spoke with also told us people had to wait to be supported to the toilet due to there not being enough staff. One person living at Parkview told us they thought more staff were needed and said "they are very often short of staff". On the day of our inspection we observed on more than one occasion that there were between six and 18 people in the main lounge and no staff were present. Some people living at Parkview required two staff to assist them with tasks such as visiting the toilet. This would leave two staff to support the remaining 30 people. We also saw one person living at Parkview was frequently involved in tasks such as moving furniture, picking up rubbish and getting cushions for people. Whilst this person appeared to enjoy carrying out these tasks, they were sometimes relied on for basic support such as getting cushions by other people living at Parkview as other staff were not always present. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in regard to staffing

During the inspection we had concerns with how the service managed risk. For instance, one person who lived at the home was judged to be at 'high risk' of falls; however there was no record of any prevention measures in place to help keep this person safe. We observed this person during the day and noticed they were very unsteady on their feet. They had fallen at the home two days prior to the inspection. As a result, the manager said that in order to prevent this happening again, this person had been placed under constant supervision by staff. However, we observed this person being assisted to walk by another resident on one occasion because there were no staff present. This placed this person at risk of falling again. Following our inspection we referred this to the local safeguarding authority due to our concerns. The registered manager told us they had "told" the person providing the support that they should not do this and that they had also told the staff not to let this person provide support to people. They also told us that alternative suitable accommodation was being looked at for this person. However, there was no risk assessment or support plan in place for staff to follow in order to ensure this person was supported appropriately and kept safe.

The registered manager told us people's weights would be measured and recorded every month. We saw records that

Is the service safe?

confirmed this, although some of the records had not been completed for the last month prior to our inspection. We saw risk assessments were in place for areas of healthcare such as nutrition and pressure sores. However, some of these assessments identified that people were at 'high risk' or in some cases 'very high risk', and there was no record of what prevention measures were in place to help keep people safe or guidance for staff to follow. Whilst we did not see evidence of any harm having occurred to people, this meant the service could not demonstrate it was taking appropriate action to ensure people's health care needs were met.

We found there was a lack of risk assessment with regards to general building safety and the environment. There was a large garden area at the home, which was well used due to the nice weather on the day of the inspection. However, it also presented various trip hazards and there was a fire escape stair case which could be easily accessed by people and cause them to fall. Also, there was a gate in the garden, which was not locked and led out near to a busy main road. Whilst it was good practice that people were able to access the garden area independently, we found there were no risk assessments in place to demonstrate how these potential risks were being managed by the service. The provider told us the gate was normally kept open from 2pm until 4:30pm to allow access by visitors but was locked at other times. Additionally, we saw no evidence to demonstrate that regular checks of the environment were undertaken by either the manager or handyman as records were not maintained.

Before the inspection we were made aware of a number of issues in relation to fire safety that had been raised following a recent fire safety inspection. We saw the provider had started to take actions to address some of the concerns raised. One concern highlighted in this report was that a person living at Parkview was smoking in one of the bathrooms and that this presented a fire risk due to the acrylic bath. The registered manager told us this issue had been addressed. However, when we approached this bathroom during the inspection we noticed a strong smell of smoke and saw a number of cigarette ends both in the bath and in the toilet of this bathroom.

The registered manager told us the person smoking in the bathroom had been "told to stop" but wouldn't listen. No risk assessment had been carried out that could demonstrate the service had considered ways to appropriately manage the risk this presented to the individual or other people living in Parkview. We discussed our concerns with the registered manager and owner and they told us they would carry out a risk assessment and purchase a separate smoke alarm for the bathroom. These issues in relation to poor risk management were a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the notifications the service was required to send us to inform us about any safeguarding concerns. There had been one notification sent in the past year. Whilst this does not necessarily indicate the service was not identifying safeguarding incidents, there was lack of clarity from both some staff members and the registered manager about how safeguarding concerns would be identified and handled. We spoke with staff to ascertain their understanding of safeguarding adults. When asked to display their understanding of safeguarding, one member of staff said; "It's about making sure residents are comfortable in their chair or have been to the toilet". Another member of staff said; "It's about ensuring there are two members of staff to assist when certain people need to use the hoist". Whilst some staff felt any concerns they raised in relation to people's wellbeing would be taken seriously, one member of staff told us when they had raised safeguarding concerns with the registered manager that they felt the information had not been acted upon initially and had not been taken seriously.

The registered manager told us all staff were trained in safeguarding and that this training was refreshed on an annual basis. One staff member we spoke with told us they had not undertaken safeguarding training, and another said they had started, but not completed booklet based training. At the time of the inspection the provider was not able to show us any records to indicate what training had been undertaken. We asked the registered manager how they knew when training was due to be refreshed for staff members. They told us they would check staff members training certificates. However the manager later told us staff members kept their own training certificates, so it was not clear that an effective system had been established to ensure staff knowledge in relation to safeguarding was up to date. Following the inspection the provider sent us invoices and a matrix that indicated that six out of the 10 care staff had not completed recent safeguarding training.

Inadequate

Is the service safe?

We saw the home had a copy of the local authority safeguarding policy and procedure. We spoke with the registered manager about safeguarding procedures. They told us they would refer incidents to safeguarding such as any arguments between residents and staff. They added that if there were things they could deal with themselves that that was not a problem. There was a lack of clarity around when incidents would be dealt with as complaints and when they would be treated as safeguarding concerns and referred to the local authority. This was a breach of regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the home managed people's medicines. We looked at the MAR (Medication Administration Records) charts and saw that they corresponded with what medication had been given, or was still left in the blister pack. We saw medicines other than creams were kept in a trolley, which was locked and kept in the treatment room when not being used. The registered manager told us creams were kept in a locked drawer in people's rooms. However, we saw creams and ointments had been left out on people's bedside tables or on top of drawers in many of the open bedrooms we looked in. This would have presented a risk that these medicines would be used inappropriately or could go missing. On the day of the inspection, medicine was administered by a senior carer who we observed giving medicines at various parts of the day. We saw that medicine was not always signed for as soon as it was given and on occasions, was signed for some time later. This meant staff may forget what medicine had been given or refused. Additionally, where PRN (when required) medicine needed to be given, there was no clear guidance for staff to refer to. This meant there was a risk staff would be unaware of how and when to give the medicine. This was a breach of regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records related to staff recruitment. We saw Disclose and Barring Service (DBS) checks had been carried out for staff. This would indicate if that person had any known convictions or if they had been barred from working with vulnerable people. The registered manager told us two satisfactory references would be obtained for all staff before they started work. However, we found there was only one reference in one of the staff member's files we looked at. The registered manager told us the other reference was probably in an email but hadn't been printed. After the inspection the provider sent us a copy of a second reference that had been obtained. This was dated two days after the inspection had taken place.

Inadequate

Is the service effective?

Our findings

During the inspection we looked at what training staff had undertaken to support them in their job role. The registered manager told us that all training had been undertaken by staff and we saw the latest resident and relatives' newsletter had a section informing people that staff were undertaking training in areas such as medicines, infection control and moving and handling. The manager told us that at present there was no training matrix in use, which made it difficult to establish what training staff had completed. We asked if we could see training certificates, however the manager told us that staff kept these at their home address and were not kept in personnel files. Following the inspection the service provided us with an updated training matrix and invoices for training carried out. This information indicated that all care staff had received mandatory update training in infection control, moving and handling and safe use of equipment. It also showed out of the ten care staff employed by the home at the time of our inspection that four had completed first aid training and four had completed safeguarding training. There were no records to indicate training in other areas such as dementia care, managing behaviours that challenge services, the Mental Capacity Act or Deprivation of Liberty Safeguards had been undertaken.

We had concerns about staff competence to deal with behaviours that could challenge. At one point during the inspection we observed a person become agitated and grab the wrist of one of two staff members supporting them. The staff asked another person living at Parkview for help and this person intervened to remove the other persons hand from the staff members' wrist. We raised these concerns with the manager who said the person should not have been asked for help. We also made the local authority safeguarding team aware of our concerns.

We also looked at staff supervision records. The manager told us these took place formally every six months as well as on-going informal supervision. The supervision records we looked at did not suggest that formal supervisions had been taking place. We raised this with the manager who said this had previously been delegated to the previous deputy manager who had now left and as a result, they had fallen behind. Two staff said they had received supervision in the past. However another member of staff we spoke with told us they had not received supervision within the past year and said they did not feel they received the support they required to carry out their role effectively. This was a breach of regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. The registered manager told us they had not submitted any DoLS applications to the local authority as no-one living at Parkview was subject to any restrictive practice. We saw that people had screening checklists in their care files that were used to identify if a DoLS application was necessary.

However, staff did not have a clear understanding about what the MCA and DoLS meant in relation to their practice. Two staff were only able to provide limited detail about MCA and DoLS and another member of staff was unsure about what it was and said they had never received training in this area. The registered manager told us there was no need to submit any DoLS applications as there was "no-one who makes for the door". This showed a lack of understanding about how DoLS are currently applied, as it is not necessary for someone to actively attempt to leave a service for practice to be considered as restrictive.

We also had concerns in relation to how staff sought consent from people who lived at the home. On three occasions we observed people seated in their chairs being approached by members of staff from behind. Their chairs were turned to face the other way without consulting them first or asking them if that was what they wanted. We observed another person who was reading a newspaper in their wheelchair. They were approached by a member of staff who said "Right, feet up" and wheeled them away in their chair without informing them where they were going or asking if they wanted to move to another part of the home. This was a breach of regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were people at Parkview who were living with dementia. There were few adaptations to the environment in order to make it more dementia friendly and enable people living with dementia to retain independence in their home. We saw some bedroom doors had people's photos

Is the service effective?

on, however these were very small and were hard to make out by members of the inspection team. The registered manager told us some people living at Parkview had objected to adaptations such as labels or pictorial signs on bathroom doors. However, there were other adaptations such as different coloured bathroom doors and contrasting colours in bathrooms that could have been considered.

We also saw there were areas where maintenance and upgrading was required around the home. One of the windows in the lounge had a small hole in it that had been stuffed with tissue paper. A relative told us this had been in this condition for approximately one year. One of the bathrooms that was accessible to people contained a bath which had a broken panel that was cracked and loose. The owner and registered manager told us improvements to the home environment were being planned in stages. We saw some improvements had been started at the time of our visit including a new call bell system. We also saw evidence that a lift was due to be upgraded and replaced.

We saw the service was involving other health professionals in order to meet people's health care needs. We saw letters of referral and outcomes from appointments with health professionals such as GPs and opticians in people's care files. One relative told us; "Medical things, like getting the doctor, the district nurse, or looking after hearing aids, is good. My [Relative] was very unsettled and it was found to be due to a water infection".

People we spoke with were generally positive about the food on offer. One person commented; "On the whole it is quite good. The new cook seems to have improved the quality of the food". However, two people told us they felt there was not much choice. We saw menus were arranged on a three week cycle and staff in the kitchen told us there was a choice of food for the evening meal, but not mid-day meal. The kitchen staff also told us they were in the process of changing the menu and said they would seek feedback from people. One person told us they had requested a different breakfast cereal but this had not yet been provided. The kitchen staff were aware of people who required special diets such as diets for people with diabetes and people who required pureed food.

Inadequate

Is the service caring?

Our findings

People and their relatives did consistently describe staff as kind and caring. One person told us; “They can be grumpy, but they’re alright” and another said “On the whole there are those who will do that little bit more but others do just what they have to do and no more”. Two relatives we spoke with also told us they didn’t think all staff were caring in their approach with people. Another relative told us they had concerns over the quality and turnover of staff, and said that some staff seemed set in their ways.

We observed interaction between staff and people living at Parkview to be limited at times. For example, at one point during the mid-day meal we observed a carer staring into the distance whilst stirring the food of the person they were supporting. They provided no interaction with the person being supported. Later this member of staff was observed to put a walking frame in front of another person then waited for a number of minutes for another staff member to come and assist this person to mobilise. During this time they stood with their hands on their hips and when the person sat next to them attempted to engage the staff member, the staff member looked at them briefly but did not otherwise respond. On two occasions we observed people request to be supported to the toilet. These requests were not acknowledged by staff straight away despite there having been opportunity to respond.

Staff told us they would ensure people’s privacy and dignity was respected by knocking before entering someone’s room and waiting to be invited in, ensuring people were dressed appropriately and making sure people were covered when possible when being hoisted or supported with personal care. However, one person told us the staff would not knock, but would just pop their head round the door. We also observed some people were wearing soiled clothes that they were not supported to change during our visit.

We saw the service had installed CCTV in areas of the home, including the lounge and communal garden. The cameras were not obvious in the communal areas and we could not see a sign advising of the presence of CCTV until this was pointed out by the registered manager. The sign was addressed to staff and informed them that CCTV was present for the purposes including crime prevention, training and monitoring. We asked the registered manager and owner what consultation had been carried out with people to ensure they were happy with the CCTV and aware of its’ presence. We were told people had been consulted when it was first installed, however there had been no consultation since its instillation over a year and a half ago.

When we viewed minutes from a relatives and residents’ meeting we saw people were informed CCTV had been installed, but there was no evidence of views having been sought in relation to its’ appropriateness or people’s wishes regarding CCTV. The minutes also noted the recordings could be used for staff training. This would raise issues in relation to people consenting to recordings of them being used for this purpose. We also saw that the CCTV monitor faced out into the main lobby area. The owner said this would ensure everyone was aware of its’ presence. However, this would also mean that anyone entering the home could view people sat in their lounge. This showed a lack of respect for people’s privacy and was a breach of regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When conducting a tour of the building we found there were not many clothes in some people’s rooms. A relative also told us clothes were rarely hung up. One member of staff told us that the lack of clothing in some people’s rooms was as clothing was still in the laundry. They also told us clothes could get mixed up and people could end up with others belongings. This showed a lack of care for people’s belongings.

Requires improvement

Is the service responsive?

Our findings

We spent time in the lounge observing interactions between staff and people living at the home and seeing how they occupied their time. We found there was very little in the way of stimulation for people and we saw no activities taking place during our inspection. At one point we were in the lounge between approximately 2pm and 2.30pm. There were 17 people seated in the lounge area and one member of staff who was sat in one of the armchairs amongst people. Despite this, there was no interaction from the staff member and most people were unengaged in any activity other than one person playing cards and two people who were reading the paper.

There was no programme of activities and a staff member told us they were not always able to do activities due to being short staffed. One person we spoke with told us they spent most of the day in bed as there was nothing to do other than play cards. One visitor we spoke with also said there was very little stimulation for their family member at the home. It became apparent that the registered manager did not allow people to watch television before 4pm. The registered manager told us this was to encourage people to interact with each other and take part in activities. However, we saw little interaction between people when the television was off, and one person told us they went to their room to watch television when it was not on in the lounge, which would have resulted in less rather than more social interaction between people.

We asked the registered manager how they involved people and where appropriate their families or advocates in care planning. The registered manager told us not many people or families were interested in care plans. However, one person we spoke with told us they would like to have been involved in care planning, but had not seen their care plan or been asked how they would like to be supported. One relative we spoke with told us they had offered to help put together their family member's care plan, but had been told it had already been written. This showed the service was not involving people in the planning of their care.

We saw people living at Parkview had different levels of independence. We saw some people were independent in many aspects of their care. One person we spoke with told us they were able to make choices such as when they go out and when they get up or go to bed. Staff told us people who were less independent would be supported to make choices such as what clothes they wanted to wear and what they wanted to eat. However, we observed the drinks round in the afternoon and saw people were handed drinks without being offered a choice. Three people we spoke with also felt they were not allowed to sleep in or had to be up for breakfast by a certain time in the morning. Whilst staff members told us people did have a choice about when they got up and went to bed, one staff member told us most people were out of bed when the morning shift started at eight in the morning. These suggested routines were based around convenience for staff rather than peoples' preferences.

We were shown a newsletter that was produced by the service for people and their relatives. This included welcomes to new staff and people moving to Parkview as well as updates about the service. This would help keep people informed about any changes. The registered manager told us meetings with residents and relatives had initially been held every three months, but at the request of relatives were now being held once or twice per year. We viewed the minutes of the last meeting, which took place around eight months prior to our visit. The registered manager told us they constantly sought feedback from people using the service but this was not documented anywhere. Following the inspection the registered manager showed us examples of completed feedback forms and service user questionnaires. However, at the time of the inspection the registered manager told us surveys of relatives and residents were not carried out in order to gain feedback on the service. This shows the system was not being operated effectively as the manager could not be expected to act on feedback provider if they had not been aware feedback was being collected. One relative told us there had been no consultation when a 'quiet room' had been converted into a bedroom.

We saw the complaints procedure was displayed. People told us they would speak with the registered manager if they had any complaints. However, two people we spoke with told us they had complained about not being able to watch the television before 4pm and said this had not been acted on. The registered manager told us there were no live complaints at the time of our visit.

One care plan we looked at had areas that had not been reviewed for around two months, and another one had areas that had not been reviewed for up to four months. The registered manager told us care plans should be

Requires improvement

Is the service responsive?

reviewed every month. They said the service was not up to date with all reviews due to increased paperwork as a result of more people living at Parkview on a temporary basis. Although we did not see any evidence this had had a negative impact on anyone, there was an increased risk that people would not receive care in line with their current needs or preferences.

Inadequate

Is the service well-led?

Our findings

At the time of our visit there was a registered manager in post. 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 registered manager told us that there had also been a deputy manager to support them in their role but that they had left recently. Staff told us if the registered manager was not on shift there would be a senior carer on duty or they could call the registered manager if they needed any advice.

The registered manager told us they encouraged good practice in the service by walking round and observing staff. Throughout the day of the inspection we saw the registered manager was actively involved in provision of care and support to people living at Parkview. This included providing support at meal times. The registered manager also told us they would also carry out the medicines round when needed. However, the registered manager was included in the staff numbers as a member of care staff. When they were not in, there would generally be an additional member of care staff on the rota. This would make it difficult for the registered manager to ensure their responsibilities both as manager of the service and as a carer were met. This arrangement in relation to staffing would also have been contributing to the issues we found in relation to staffing as discussed in the safe section of this report. The registered manager told us there was no formal tool used to determine what staffing levels were required to be able to meet the needs of people living in the home. They were not able to demonstrate that an alternative effective way of determining staffing levels had been used.

We looked at the systems in place to monitor the quality of service provided at the home. We saw that regular audits were undertaken of care plans and medication. We saw that where shortfalls had been identified, this had been noted along with any actions to prevent any re-occurrences. Despite these being in place, we found that no other auditing of practice at the home was being undertaken. There were no checks or audits being undertaken in relation to infection control, the environment, staff training and staff supervisions. We found the home to be unclean and require maintenance in a number of areas. These are areas that effective infection control and environmental audits could have identified so that appropriate measures could have been put in place to reduce risk and improve standards.

We also found staff knowledge and competence was variable in relation to managing behaviours that challenged, and in relation to safeguarding. There was no effective system to ensure training in these areas had been completed recently by staff as there was no training matrix available at the time of the inspection. The registered manager told us they would check training certificates to determine when training was due. As training certificates were not kept at the service, the registered manager could not demonstrate they were able to monitor and manage this aspect of the service effectively. The failure to undertake effective audit to assess and monitor the quality and safety of service provision was a breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received a mixed response when we asked staff if they liked working at Parkview and if they felt they were treated fairly. One member of staff told us; "Everybody is friendly and gets on" and another said "[The registered manager] looks after their staff". However, two staff said they felt they were not treated fairly and were not happy. One member of staff said they had raised issues including concerns in relation to staff welfare. They said their concerns had not been taken seriously by the registered manager. We raised this with the registered manager after the inspection who said they were unaware of any particular issues.

We asked to see copies of any staff meetings that were held. These could not be located at the time of our visit so we asked for copies to be sent following the inspection. The most recent minutes received related to a meeting held over one year before our inspection visit. One staff member we spoke with said there had not been a staff meeting in the last 12 months and said they would love one to put their points across. The registered manager told us staff meetings would be held if any problems came up or there were any changes. This would make it difficult for the service to actively involve staff in the development of the service and empowering them to provide feedback or put forward ideas.

We asked the registered manager what they did to encourage a positive culture within the home. They told us

Inadequate

Is the service well-led?

the first thing they told staff when they stared work was to treat people living at the home as if they were their own relative. They also told us “We are very proud of the way people are looked after”. We asked what the biggest challenge they faced was. The registered manager acknowledged that Parkview was an old building and that work was required to update it.

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 10 HSCA (RA) Regulations 2014 Dignity and respect Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Consent was not sought before providing service users with care. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes were not established or operated effectively to mitigate risks to service users or assess, monitor and improve the quality and safety of services provided. Regulation 17(1) (2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Risks to service users were not adequately assessed, actions were not taken to mitigate risk, medicines were not managed safely and adequate measures were not taken to assess and mitigate risks from the spread of infections. Regulation 12 (2)

The enforcement action we took:
We issued a warning notice. The service is required to become compliant with the regulation by 16 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment. There were not effective systems and processes operated to investigate or prevent abuse. Regulation 13

The enforcement action we took:
We issued a warning notice. The service is required to become compliant with the regulation by 07 August 2013.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1)

The enforcement action we took:
We issued a warning notice. The service is required to become compliant with the regulation by 16 August 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Staff did not receive appropriate support, supervision or training. Regulation 18 (2)

The enforcement action we took:
We issued a warning notice. The service is required to become compliant with the regulation by 16 August 2015.