Park Vista Care Homes Limited

Park Vista Care Home

Inspection report

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Ratings

Is the service safe?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 28 April 2015. Two breaches of legal requirements were found. This was because staff had not responded to allegations of abuse and had not reported the allegations to the local authority safeguarding team. Risk assessments relating to health and challenging behaviour had not been carried out or recorded.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We undertook this focused inspection on 13 November 2015 to check that they had followed their plan and to confirm that they now met legal requirements.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Park Vista Care Home on our website at www.cqc.org.uk.

Park Vista Care Home provides accommodation for up to 59 people who require personal care or nursing care. The home provides support for older people, some of whom are living with dementia. There were 47 people living in the home at the time of our inspection.

There was a new manager in post at the time of the inspection but they were not yet registered with the commission. 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.

At our focussed inspection on 13 November 2015 we found that the provider had not fully completed their plan which they told us would be completed by 31 August 2015. The actions to safeguard people from harm had been improved, however the assessment of the risks to the health and safety of people meant legal requirements had not been met.

Summary of findings

The provider had taken action to ensure suspicions and allegations of harm were reported to the manager or provider in line with the policies and procedures in the home. However some staff still did not recognise when people may have been hurt.

People who had behaviours that challenged themselves or other people did not have their risks identified nor were there details of how the risks could be minimised. Staff did not have the information they needed to support and respond appropriately with people who had behavioural challenges.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe

We found that action had not been taken to improve the safety of the service.

People's records did not always identify their risks or how they could be minimised.

This meant that the provider was not meeting legal requirements.

People were protected because most staff did recognise possible harm. Information about suspicions and allegations of harm had been reported to the manager or provider to ensure people were protected from harm.

Requires improvement

Park Vista Care 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. We undertook an unannounced focused inspection of Park Vista Care Home on 13 November 2015. This inspection was completed to check that improvements to meet legal requirements, planned by the provider after our comprehensive inspection carried out on 28 April 2015, had been made. The inspection team inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting some legal requirements in relation to that question.

The inspection was undertaken by two inspectors. Before the inspection we looked at all of the information that we held about the home. This included the provider's action plan, which set out the action they would take to meet legal requirements. The information we held also included information from community health and social care agencies and information from notifications received by us. A notification is information about important events which the provider is required to send to us by law.

During the inspection we spoke with three members of care staff, one laundry assistant and one registered nurse. We also spoke with the manager and the provider. We looked at records in relation to safeguarding and looked at the care plans and risk assessments for three people.

Requires improvement

Is the service safe?

Our findings

At our comprehensive inspection of Park Vista Care Home on 28 April 2015 we found that people were not always protected against the risks of harm because effective systems of reporting were not being used. This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that people were not protected because assessments to manage and minimise potential risks were not always completed. This was a breach of Regulation12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our focussed inspection of 13 November 2015 we found that the provider had not followed the action plan they had sent to us to meet shortfalls in relation to the requirements of Regulation 13 described above.

At the last inspection on 28 April 2015 we found that staff had not followed the provider's policies and procedures in reporting any incidents to protect people from the risk of harm.

During this focused inspection we saw improvements had been made. Six reports and investigations about how the staff had dealt with incidents of harm had been sent to the local authority. There was evidence that the local authority safeguarding team had been happy with how the incidents had been dealt with. However we saw that two registered nurses had not made a referral to the local authority in relation to a large bruise that was found on the arm of one person living in the home. The registered nurse in charge on the night the bruise was noted, recorded details on the person's body chart and left a note in the shift changeover book. They showed the morning registered nurse the person's arm at 07:30a.m. Neither nurse had understood their roles and responsibilities in relation to identifying and responding appropriately to possible harm. Evidence showed that the nurses had not followed the providers' policies and procedures, which meant people were at risk.

One member of care staff told us they had been working in the home for seven months but had not undertaken any training in relation to protecting people from harm. However, when they were asked what action they would take if concerned, stated, "I would tell the senior in charge and would complete the turning chart and body map." The care staff and laundry assistant also said they would report any issues to the senior person on duty.

This meant that people were not protected because some staff did not follow the provider's policies and procedures in relation to protecting people from harm.

This was a breach of Regulation 13 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 28 April 2015 we found that people did not have health and safety risk assessments completed or reviewed.

There had been some improvements in relation to the health risks for people. This was because the level of risk of people not having enough to eat and drink was now identified through the malnutrition universal screening tool (MUST). People who were at risk of malnutrition were being weighed regularly and the manager audited the records to ensure referrals to the appropriate health care professionals were made. There was also a new system of red trays in place to indicate to staff that those people may need assistance to eat their meals. The manager said that they had started to complete one area in one person's care plan and risk assessment. We looked at the information and this provided staff with the individualised assessment of the risks so that the person could be safe.

However, when we looked at the records of people who were at risk in relation to their behaviour that challenged themselves or others, there was no information provided to staff on how to deal with any situations that occurred. For example, we looked at two combined care plans and risk assessments. The risk for one person was recorded as 'challenging behaviour', but there were no details of what that meant or what type of behaviour the person displayed. The aim of the person's care was, 'to ensure behaviour is being controlled and managed'. Again there were no details of what that meant for staff. In the second person's file we saw that the risk was 'challenging behaviour, agitation and verbal aggression'. One member of staff said they were aware of the person's behaviour and what they needed to do to de-escalate the situation. However there was no information recorded in the care plan and risk assessment in relation to this. The manager told us that most people

Requires improvement

Is the service safe?

who had behaviour that challenged themselves and others had the same care plans and risk assessments and confirmed that the information did not provide staff with the necessary information to keep people safe.

People were not protected because assessments and guidance for staff to manage and minimise risk in relation to behaviour that challenged people and others had not been completed.

This was a breach of Regulation12 (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services were not protected against the risks associated with concerns about abuse because effective systems of reporting were not used. Regulation 13 (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 People who use services and others were not protected because assessments to manage and minimise risk had not been completed. Regulation 12 (2)(a)

The enforcement action we took:
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