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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This unannounced inspection took place on 16, 18 and 21 September 2015.We last inspected Parkview Nursing and Residential Home on 14 April 2015 when we rated the service as 'inadequate'. We found seven breaches of the regulations, which were in relation to training, staffing levels, safeguarding, medicines management, infection control, managing risk, monitoring of the safety and quality of the service, need for consent, dignity and respect and seeking consent.

At this inspection we found the provider had made improvements and was meeting the requirements of three of these regulations in relation to the issues we previously found around safeguarding, dignity and respect and seeking consent. However, the required improvements had not been made to meet the requirements of four of the previously identified breaches of the regulations.

Summary of findings

Overall we found 11 breaches of the regulations. These related to the safety of the premises, safe management of medicines, infection control, assessing and managing risk, employment of fit and proper persons, meeting nutritional and hydration needs, staffing, training, assessment of needs and preferences, records and systems in place to monitor the safety and quality of the service, and requirements relating to the registered manager. We are considering our enforcement options in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded.

Parkview Residential and Nursing Home is a large property built on three levels with a passenger lift to all floors. The home provides accommodation and personal care for up to 32 people. The home did not provide, and was not registered to provide nursing care at the time of our visit. The provider has requested that their name be changed to reflect this. The home has a garden area to the front and rear is situated close to Bolton town centre. It is on a main bus route and faces a local park. At the time of our inspection there were 24 people living at Parkview.

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 '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 had concerns that the registered manager did not have the required skills to manage the service effectively. We looked at training records and found the registered manager had not received recent training in moving and handling or medicines administration. These were both areas where we found examples of poor or unsafe practice.

A safe environment was not maintained for people living at the home. We found a door in front of a steep staircase to the basement was unsecured on several occasions. We looked at records of servicing and maintenance and saw the electrical systems check had shown the system to be 'unsatisfactory'. Several faults had been identified by an electrician as requiring urgent or immediate action. The provider had not taken action to ensure the electrics were safe despite this report having been carried out around two months previously. This put people at risk of potential harm.

Medicines were not managed safely. We found stocks of medicines that were not on people's medication administration records and found missing signatures on the records. We found two people had not received their medicines as prescribed. The home was not following its documented procedures around medicines and stock control was poor. We observed a staff member following unsafe practice when administering medicines.

People commented that the cleanliness of the home had improved since our last visit. However we had continued concerns in relation to the effective prevention and control of infections. We observed a paddling pool containing urine that was sat in the bath of a bathroom accessible to people using the service that was not cleared up promptly. The rationale for using this item for this purpose was not clearly recorded. There were no audits of infection control procedures other than cleaning check-lists.

The night shift was staffed by two carers from 8pm to 8am to provide support to the 24 people living at the home. Staff and the registered manager were not able to explain how support would be provided should one of the people that required two staff to support them required assistance at the same time as other people who were described in their care plans as requiring 'constant supervision and observations' were out of bed. One person fell from bed during our inspection. The registered manager told us this was because they wanted to sit with friends in the lounge. They told us they were unaware why this person was still in bed, but thought it was because the night staff must have been busy.

The provider had not followed safe practice in the recruitment of staff. We found some staff who were working during out inspection did not have the required checks in place to help ensure they were of good character and suitable to work with vulnerable adults.

We found that not all staff who were providing support with moving and handling had received the appropriate training. We also observed unsafe practice in relation to moving and handling. The service supported people with a wide range of needs, however no specialist training had

Summary of findings

been provided, for example in supporting people with mental ill health or drug addiction. Staff had a poor understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They were not able to explain how they would support people living with dementia effectively, despite having attended training in this area.

We saw improvements were underway to improve the physical environment at the home, such as the replacement of carpets and bathrooms. However the provider had not acted to make the environment more 'dementia friendly' despite this having been raised as an issue at our last inspection.

Whilst referrals had been made promptly to other health professionals, the records did not always demonstrate that advice in relation to food and nutrition was being followed. Staff told us they thought the records were not accurate. We looked at one person's records, which appeared to have been amended between the first and second days of our inspection.

Most relatives we spoke with told us they were made to feel welcome and felt their family member was well cared for. The majority of interaction we observed between staff and people using the service were friendly and respectful. However, we observed a lack of effective communication by one staff member when supporting a person who was becoming distressed.

At our last inspection we had raised concerns that the provider was using CCTV in indoor communal areas and had not consulted with people or ensured they were aware of its presence. The CCTV in the lounge area had been turned off. However, CCTV recordings were still being made in the reception area and communal garden and people we spoke with were unaware of its presence. We have made a recommendation for the service to review guidance on the use of surveillance in care homes.

Some people living at the home had a high level of independence and told us they were allowed the freedom to come and go as they pleased. However, one person told us that staff discouraged them from going out and told us they had not been given a reason for this. This meant their independence was not being supported.

We saw various games and activities taking place, although there were also missed opportunities for interaction. We observed that staff sometimes sat next to people but did not attempt to interact with them. Some people told us they enjoyed entertainment that the home put on such as singers.

Most care plans contained some information about people's preferences in relation to daily routines, hobbies, interests and social history. However, we saw two people did not have a full care plan in place and that there was no information on preferences recorded. The admission assessment for one person was incomplete and the service had not carried out a risk assessment for this person.

We saw the service kept a record of complaints. One relative told us their complaint had been addressed effectively. There had not been any meetings for relatives for over one year. The registered manager told us that relatives had requested to only have the meetings infrequently. The relatives we spoke with during the inspection did not express a desire for more frequent meetings, however we saw one person had written to the service and noted that they had wanted to raise concerns at a relatives meeting but that this was overdue. There was no evidence of the service having consulted with families on the frequency of meetings.

Relatives and staff commented that they had seen improvements within the service since our last inspection. We saw a schedule of works to improve the environment was displayed. Most visitors and people living at the home told us they felt comfortable discussing any concerns they might have with staff or the registered manager.

We found a lack of effective systems and processes to effectively monitor the quality and safety of the service. For example, there were no checks of recruitment procedures or infection control. Audits of medicines and care plans were limited in depth and were not effective at identifying issues. The service was not displaying the rating from its last inspection on their website despite having been reminded of this requirement.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

Summary of findings

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still 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 this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

An electrical system safety test had identified unsafe electrics that required 'immediate' or 'urgent' action. The provider had placed people at risk by not taking action to get these faults fixed.

There were two staff on duty from 8pm until 8am to provide support to 24 people. This was not sufficient to provide support to all people living at the home based on the level of support they required.

Medication administration records indicated people had not received their medicines as prescribed. We observed the registered manager following unsafe practice when administering medicines.

Is the service effective?

Inadequate

The service was not effective.

Records of food and fluid intake did not demonstrate that the service was following the advice of other health professionals. Records of fluid intake showed some people had received very little fluid intake. Staff told us they thought the records were incorrect.

Some staff were undertaking tasks such as moving and handling without having sufficient training. Staff understanding of how to support people living with dementia or other care and support needs was poor.

There were few adaptations to the environment to make it more 'dementia friendly' despite this having been raised as a concern at our previous inspection.

Is the service caring?

Requires improvement

Not all aspects of the service were caring.

Some people living at the home had a high level of independence and told us they were able to come and go as they pleased. However, another person we spoke with told us they used to go out independently but that they were now discouraged from doing this.

Most interactions between staff and people were positive and friendly. However on one occasion a staff member did not offer reassurance or communicate effectively with a person they were providing support to.

Visitors told us they were made to feel welcome and told us they thought their family members were well cared for.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive.

Summary of findings

The care plans for two people were incomplete and did not contain information in relation to preferences, interests or hobbies.

People were not asked what they wanted for breakfast on a regular basis. Bowls of cereals had been laid out for people before they entered the dining room.

We saw activities such as games taking place and saw occasions when staff spent time with people talking or reading the newspaper. However, we also saw there were missed opportunities for interaction when staff did not interact with people even though they were not completing other tasks.

Is the service well-led?

Inadequate

The service was not well led.

Action had not been taken since our last inspection to put in place systems to ensure the quality and safety of the service was adequately monitored. The provider had failed to act on known areas of risk such as the electrical system.

We had concerns in relation to the skill and competence of the registered manager. There was no evidence the registered manager had received recent training in medicines or moving and handling, and these were areas where we identified poor and unsafe practice.

The service was not displaying the rating from its' last inspection on its' website despite having been informed about this requirement on two previous occasions.

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 16, 18 and 21 September 2015 and was unannounced.

The inspection team consisted of three 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 previous inspection reports and notifications the service is required to send us about important events such as safeguarding and serious injuries. We reviewed any information and feedback that had been sent to us from people involved with the service such as staff members and relatives. We also reviewed the 'provider information return' (PIR) that the service had sent to us. The PIR is a document we send services that requests key information about the service relating to whether the service is safe, effective, caring, responsive and well-led.

We contacted the local authority safeguarding adults team, contracts team, infection control team and care management team for feedback on the service. During the inspection we spoke with 12 people who were living at the service and six people who were visiting their friend or relative during our inspection. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 12 staff during the inspection. This included the registered manager, the director, eight carers, a housekeeper and an external professional who was working with the service part-time on a temporary basis. We also spoke with one visiting health professional. We looked at records relating to the care people were receiving including 11 care plans, 24 medication administration records (MARs), risk assessments and records of food and fluid intake. We also looked at records relating to the running of the service including service and maintenance records, audits and 10 staff personnel files.

Inadequate

Is the service safe?

Our findings

We had concerns in relation to the safety of the premises. On the first day of the inspection we found a door that was located directly in-front of a steep staircase to the laundry in the basement was unsecured. We alerted the handyman to this who told us the lock was sticking and that this would be fixed immediately. However, on the second day of the inspection two days later, we found the door was unsecured on two further occasions throughout the day. This would place people at risk of falling were they to access this area.

We looked at records of servicing and maintenance carried out of the premises. We saw that a test of the electrical installation had been carried out over nine weeks prior to our visit. This had found the condition of the electrical system to be unsatisfactory. The report identified nine areas where the condition of the electrics was identified as 'unacceptable' and requiring 'immediate' or 'urgent' work due to being immediately or potentially dangerous. We looked at some of the identified faults, which included a cracked electric socket and lights where the outer covering for the wire had been pulled back. We confirmed these faults had not been fixed. The director of the company told us works were planned to start the following week to undertake repairs of the electrics. The electrician whom had been booked to undertake this work was called during the inspection and fixed the faults previously identified as requiring immediate action. They told us they did not believe anyone was at immediate risk from the electrical system. The provider had placed people at risk by not ensuring known faults with the electrical system had been fixed in a timely manner. We also made the local safeguarding authority and environmental health aware of our concerns in relation to the electrics.

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not ensured that the premises were safe to use for their intended purpose.

At our last inspection on 14 April 2015 we found medicines were not being managed safely and this was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had not been made.

Two of the medication administration records (MAR charts) we looked at did not have a photo of the person on the record. This increased the risk that medicines could be given to the wrong person. At our last inspection we identified that there were no 'when required' (PRN) protocols in place for people who had been prescribed medicines on an 'as and when required' basis. 'When required' protocols provide information for staff about when they should give these medicines. We found there were still no 'when required' protocols in place for the four people's medicines we reviewed where a protocol would be required. The registered manager confirmed there were not PRN protocols in place and showed us a blank template that they intended to use for when required protocols. This is poor practice and was contrary to the home's medicines policy, which stated there should be a specific plan in place for any 'when required' medicines.

We found missing signatures on the MAR charts for three people. This meant the provider could not be certain these people had received their medicines as prescribed. We also found stocks of various medicines that did not appear on people's MAR charts. The registered manager told us some of these medicines had been discontinued and that the stock should have been disposed of. The registered manager was unsure why other medicines were in stock but not on MAR charts. On the second day of our inspection the registered manager told us the pharmacy had issued the medicines but not provided a MAR chart. This had meant that two people had not received their medicine as prescribed. We asked the registered manager if any checks were carried out when ordering and receiving medicines to ensure any such errors were picked up. They told us; "They obviously didn't check. We should do. I didn't even know the [medicine] had come in." Between the first and second days of the inspection the provider had arranged for the pharmacy to come in to help sort the stocks. They had also contacted people's GPs where they had missed medicines to seek advice.

During the inspection we observed the registered manager carrying out the medicines round. We saw they had dispensed tablet and liquid medicines into 10 separate pots. The pots contained a scrap of paper with the person's room number on it. The registered manager then took these pots to administer medicines to each person. This method of dispensing medicines is an unsafe, high risk practice as it increases the risk of medicines being administered to the wrong person. The medicines trolley

was also left open whilst medicines were being dispensed. This meant the medicines were accessible to people and were not being kept securely. Although the registered manager was a registered nurse, we found they had not received any recent formal training in medicines.

The provider had failed to ensure medicines were managed safely, which was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection on 14 April 2015 we found inadequate procedures and practices were in place to prevent and control the spread of infections. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found some improvements had been made in some areas, but also found additional issues in relation to infection control. The service was not meeting the requirements of this regulation.

One staff member and one relative both commented that the environment was cleaner than it had been during our last inspection. We also saw positive feedback the service had received from the infection control team in relation to progress the home had made. However, there were a number of new issues in relation to cleanliness and infection control that were picked up during our inspection. Some of these issues were also noted by the infection control team during a subsequent visit. We observed one staff member using the same hairbrush to brush the hair of several people, which was poor practice in relation to hygiene and dignity. This staff member had not received training in infection control.

At another point in the inspection we observed a blow-up paddling pool containing urine that was sat in the bath of one of the bathrooms. This bathroom was accessible to people living at the home. Staff told us the paddling pool was used to catch urine due to the behaviour of a person living at the home. The registered manager confirmed the decision to use the paddling pool had not been documented in this person's care plan as an agreed management strategy. We checked the bathroom again around two hours later and saw the paddling pool was still in the bath. This showed the provider was not maintaining adequate standards of cleanliness and also presented a risk of spread of infection to others. We found there was no hot water in the laundry in the hand-wash sink and there were no audits of infection control procedures other than cleaning check-lists.

The provider was not acting in accordance with the code of practice on the prevention and control of infections in relation to the maintenance of clean and appropriate environments and systems in place to manage and monitor the prevention and control of infection. **This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not acted to prevent or control the spread of infections.**

At out last inspection of Parkview on 14 April 2015 we found there were not sufficient numbers of staff deployed and that this had an impact on the care people received. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had not made the required improvements and was still in breach of this regulation.

All the people we spoke with living at Parkview told us they thought there were enough staff on duty in the day to meet their needs. However, three of the six people we asked about staffing levels told us they thought there were not many staff on the night shift. One person said; "They are short of staff in the mornings I feel. There is nobody to make me a drink when I need one. All the staff seem to rush about here".

Since our last inspection the day-time staffing levels had been increased from four staff (including the registered manager), to four or five staff in addition to the registered manager and two apprentices. We asked the registered manager what tasks the apprentices undertook. They told us they would only work supervised by other staff and that they supported with activities and tasks such as setting the tables. However, on our first day of the inspection we observed that the apprentices were left alone on several occasions to provide staff cover for the lounge area. We confirmed with staff and the apprentices who both confirmed this was not unusual.

At another point in the inspection we observed an apprentice alone in the lounge, supporting an individual with their lunch. The registered manager had told us this person was living with dementia and required support that was 'more or less one to one'. Their care plan also identified

them as being at high risk of falls. The apprentice had not received training in moving and handling or other aspects of dementia care provision and therefore did not have the required skills or experience to be providing such support. The registered manager told us they should not have been left to support this person. On day two of our inspection, an external professional who was working with the service described a system they had put in place to ensure the apprentices were not left unsupervised. We did not see the apprentices being left unsupervised on the second day.

We asked six staff who worked in the day whether they thought there were enough staff to provide people with the support they required. Three staff mentioned there were more care staff around in the day; however two staff told us they thought more staff were required and one said they were not sure about staffing levels. We looked at the dependency tool the service had developed since our last inspection. Dependency tools are used to help services determine staffing requirements based on people's support needs. This indicated that five people required the support of two staff for support to the toilet and eight people required the support of two staff to transfer at various times through the day. In addition, five people's care plans or risk assessments indicated they required constant observation and supervision in relation to risks around mobility, and one person was identified as requiring three staff to assist when hoisting. These support needs were not identified on the dependency tool.

We asked staff what impact current staffing levels in the day had on care people received. One member of staff said it would help to have an additional staff member as the lounge would not have to be left unsupervised as often. Another staff member told us people may have to wait to receive support, particularly if other staff were on a break. They also told us an additional member of staff would help provide cover if someone had a fall and another staff member was required. On the first day of our inspection we saw the lounge was left without staff supervision on several occasions, including when people identified as requiring 'constant supervision and observation' were present in the lounge. The external professional showed us a recording system that had been put in place to ensure the lounge was always supervised on day two of our inspection. At one point in the inspection we were present in the lounge whilst one person asked to be supported to the toilet and said "I need to go now." There was only one staff member in the lounge, who told this person they would have to wait for another staff member to ensure there was staff cover for the lounge. The staff member told us there were two staff working at that time as two staff were on a break. Five minutes later, the person requesting to be taken to the toilet was still waiting for staff support and the staff member covering the lounge had made no attempt to call another member of staff.

At the time of our inspection there were 24 people living at Parkview. Staffing levels at night had not increased since our previous inspection. Two staff worked the night shift from 8pm to 8am. Night staff told us their duties included conducting the night medicines round, which would be carried out by one staff member. We asked how support could be provided as required given the number of people identified as requiring two to one support with mobility and transferring in addition to people whose care plans identified that they required constant supervision and monitoring. The night staff were not able to explain how this was possible. One member of staff told us; "Providing everything is quiet everything is ok. Other times people won't settle and things can be difficult with only two staff." Another staff member said they felt they managed with the current workload, but that if more people moved in a third member of staff would be needed for safety.

Both staff members said it would be difficult to support people in an emergency situation such as an evacuation in the event of fire. We asked the registered manager who would provide support to people requiring two to one assistance at the same time as people requiring constant supervision and observation were out of bed, or whilst one of the night staff was conducting the medicines round. They replied; "At the moment nobody, but we're open to suggestions." At around 9:30am on the second day of our inspection we became aware that one person had fallen out of bed. The registered manager told us this had occurred due to the person wanting to get to the lounge to sit with their friends. We asked if this was the case, why they had not been supported to the lounge earlier. The registered manager replied; "I've no idea. The night staff must have been busy."

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure there were sufficient numbers of suitably qualified, competent and skilled persons deployed.

Inadequate

Is the service safe?

We checked to see if staff had been safely recruited and looked at 10 staff personnel files. We saw that staff had references in place and had completed an application form. One staff member we spoke with told us they had not had an interview before being appointed. The registered manager told us interviews were conducted but a record of interviews was not kept. This meant the service was not able to demonstrate it had taken adequate steps to determine staff had the required competence, skills and characteristics to undertake the role they were appointed to.

We saw there was no identification on file for one staff member as is a requirement. In six of the ten files we looked at we saw no disclosure and barring service (DBS) checks had been undertaken. DBS checks show whether the applicant has any convictions or is barred from working with vulnerable people. DBS checks help employers make safer recruitment decisions and it is required that these checks are carried out before staff start work. These members of staff had already commenced employment at the home and this put people at risk as they may have been receiving care from staff who were not of suitable character to work with vulnerable people.

The registered manager said that these checks were undertaken by an administrative employee, but that they had been on annual leave during the period these staff were recruited. The manager said these staff would have been supervised during this period; however we saw this was not the case during the inspection. We looked at the providers DBS policy, which stated employees should not be offered a position until a DBS check was in place.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not followed recruitment procedures to help ensure only people of good character and with the required competence and skills were employed.

At our last inspection on 14 April 2015 we raised concerns about how the service assessed and managed risk. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we continued to have concerns in relation to the how the service assessed and managed risk. The service was not meeting the requirements in relation to the regulation.

At our last inspection concerns were raised about a potential fire risk caused by an individual who was smoking in a communal bathroom. The provider told us about the actions they had taken to reduce this risk, including supplying metal bins, fitting smoke alarms and creating a designated smoking area inside the home in addition to the outside smoking area. We saw the service had used a Care Quality Commission (CQC) advice note to check what actions were required in relation to allowing smoking in certain areas of the building. However, we saw the risk assessment that had been carried out for the individual who was smoking inside was not up to date. The risk to this individual and others had not been assessed as the risk assessment had no reference to the individual being allowed to smoke indoors. We looked at the environmental risk assessment that had been carried out for the home and this stated smoking was not allowed inside the home. The fire risk policy for the home was dated 2007 and there was no evidence of any review having been carried out since this time.

During the inspection we saw the carpet was being replaced in one stairwell and corridor. There was a single line of hazard tape across the downstairs door. However, we saw people who lived at the home ducking under the tape and accessing this area where the carpet had been removed on several occasions. This showed the management of potential risk to people using the service had not been adequately assessed or controlled.

We saw some people had risk assessments in place in relation to areas of risk such as nutrition, pressure sores, falls and mobility. Measures to control risks had been identified in the associated care plans. However, we saw three people's risk assessments were out of date or had not been completed. One person's moving and handling risk assessments did not match the support currently being provided to them. Another person had moved to the home over two months prior to our visit and had no risk assessment in place. This was despite an assessment by the local authority that identified a number of potential risks and specifically stated that the home should carry out their own risk assessments in relation to certain areas of care provision. We saw another person's risk assessments in relation to nutrition and pressure sores had initially been reviewed on a monthly basis, but there was no evidence of review for around nine months prior to our visit.

Inadequate

Is the service safe?

These issues were a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to adequately assess or control the risks to the health and safety of people using the service.

During the inspection we noticed there was frequently unrestricted access into the home through both the front and rear exits. Although the front entrance was on self-locking mechanism, we saw that this had been placed on the latch at various times throughout the inspection. There was a sign on a gate to the rear of the property stating the gate would be open during certain hours to facilitate visitor access. However, we saw this gate was also open outside these hours. We looked at the environmental risk assessment for the home. This was limited in depth, consisting primarily of yes/no tick boxes and did not cover building security.

At our last inspection we had concerns about procedures in place to enable the provider to identify and respond appropriately to safeguarding concerns. This was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the service was now meeting the requirements in relation to this regulation.

Since our last inspection staff and the registered manager had undertaken training in safeguarding. We saw that a new record had been introduced that was used on handovers on each change of shift. This required staff to state if there had been any safeguarding issues on the shift. This would help ensure any issues were recorded and followed-up appropriately. The registered manager told us no safeguarding concerns had been identified on the sheets since their introduction.

Most staff we spoke with were aware of the actions they should take should they have any safeguarding concerns, and were able to tell us how they would recognise signs of possible abuse or neglect. One member of staff who had recently started work at the service had not received safeguarding training and was not able to explain what action to take if they witnessed abuse. However, by the second day of our inspection, the external professional told us they had provided a safeguarding briefing session to newly appointed staff members to address this concern.

Inadequate

Is the service effective?

Our findings

All the people we spoke with told us they always had enough to eat and drink. People's opinions of the food were mixed. Of the ten people who talked with us about the food, two made positive comments, two made negative comments and six thought the food was "alright" or "could be better." Comments included; "The food is not bad and I can always get a drink" and; "I do alright for food and drinks and would say the food was OK."

We observed the mid-day meal, which consisted of steak pie with onions, mashed potatoes and broccoli. This was the only choice on the menu; however people told us they could request an alternative if they did not like what was on offer. We saw people received the support they required to eat and drink. We also observed drinks and biscuits being offered to people throughout the day.

We saw referrals to other health professionals such as speech and language therapists or dieticians had been completed in a timely manner where concerns had been identified in relation to people's eating and drinking or nutrition. We observed that two people that required additional support to eat safely had been provided with support in accordance with their care plans. However, one record we reviewed did not demonstrate that person had been receiving care in accordance with advice given by health professionals.

This person had received advice from a dietician to have their weight recorded weekly, for certain supplements to be given and for accurate records of intake to be recorded. This person's monthly weight records showed they had lost weight and the service had taken action by getting back in contact with the dietician. However, we had concerns as the records of food and fluid intake in this person's file did not show that supplements had been given as advised. As a result of our concerns we made a referral to the local authority safeguarding team.

We looked at food and fluid intake charts and saw very low amounts of fluid intake were recorded for some people, which would put them at risk of dehydration. One person's chart showed they received around 140ml to drink per day, and that on one day they had had no fluid intake. A member of staff we spoke with told us they thought the recording had been incorrect and the person would have received drinks.

These issues in relation to food and nutrition were a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a visiting health professional who told us they were called out promptly by the home should there be any concerns about a person's health. They said the home generally acted on advice, although sometimes they would have to 'ask a few times'.

At our last inspection on 14 April 2015 we found little evidence of staff training and had concerns about staff competence. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider was still not meeting the requirements in relation to this regulation.

We looked at the service's training matrix. This showed that of the 19 care staff and including the registered manager, approximately 63% had completed fire safety training, 53% had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA and DoLS) and 32% had completed training in moving and handling. The training matrix showed one member of staff had completed first aid training, and none of the night staff had completed this training. This would place people at increased risk if they required emergency care during the night shift.

We spoke with three staff that had recently started working at the home. These staff told us they had been told about aspects of care such as hygiene and moving and handling. One member of staff told us they had shadowed other staff for about four or five days prior to working alone. The other two staff told us they had not shadowed other staff, but told us they received help when they needed it, and felt competent to carry out their role. We looked at the induction paperwork for one member of staff who had started working at the home around two months previously. None of the tasks identified on the induction checklist had been signed off to show the staff member had completed them.

Staff understanding of the MCA and DoLS was poor, including amongst those whom had undertaken training. None of the six staff we asked about MCA and DoLS were able to explain what it was or how they might identify restrictive practice. We spoke with two staff who told us

they had attended training in dementia. However, neither staff member was able to explain what they had learnt in the training that would enable them to support people living with dementia effectively.

From looking at care plans and speaking with staff we were aware that the home provided support to both younger and older adults, and also people with a wide range of support needs. This included people living with dementia, people with drug and alcohol addiction, people with physical support needs and people with mental ill health. We asked the registered manager what training staff had received to enable them to support these people with their specific care needs. The registered manager told us staff hadn't had much training in these areas, but that these people did not require much in the way of support.

During the inspection we observed staff undertaking moving and handling tasks. When we checked the training matrix we saw that some of these staff, including the registered manager, did not have training in moving and handling or using the hoist. On several occasions we observed poor practice in relation to moving and handling, such as people being lifted under their arms, an occasion when wheel-chair foot-plates were not in position whilst someone was being pushed in a wheelchair, and one person who was left sitting in a hoist sling for an extended period. The registered manager told us they instructed staff how to support people with moving and handling tasks and that they were aware of the correct procedures through observing visiting professionals. However, there was no evidence that the registered manager had undertaken any recent training in moving and handling or had their competency to carry out and instruct in moving and handling assessed. This placed people at risk of being supported incorrectly or unsafely.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not ensured staff received appropriate training and professional support.

At our last inspection there was no documentary evidence that staff supervision took place within the home. During this inspection we saw evidence of staff supervisions taking place. Records showed areas including training, work performance, working unsupervised, meeting people's needs and communication with people were discussed. One staff member told us they were asked how they were getting on during supervision and found supervision with the registered manager useful. Another staff member said they received supervision once per year, but that they were able to speak with the registered manager if there were any issues between supervisions. A third staff member confirmed they received supervision, but told us it would be better if it was more formal as it was carried out quickly.

At our last inspection on 14 April 2015 we found staff were not always seeking consent from people before providing care and support, which was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider was now meeting the requirements in relation to this regulation.

All the people we spoke with who were living at Parkview told us staff would ask their permission before providing any support with care. Staff told us they would explain what support they were going to provide and would ask questions in order to understand if people were happy for them to provide the support. We asked one staff member what they would do if people were not able to provide consent to every-day care and support. They told us they would look in the persons care plan for further clarification.

The Care Quality Commission has a duty to monitor activity under 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 there was no-one living at Parkview who had an authorised DoLS in place at the time of our visit. We saw the registered manager was in the process of submitting a DoLS application for one person following the advice of another health professional. The registered manager was aware how to make a DoLS application to the local authority and was able to tell us in what circumstances this would be required. As previously noted, staff did not have a good understanding of the MCA /DoLS. One staff member told us they thought there were three or four residents whom had an authorised DoLS, although this was not the case.

At our last inspection on 14 April 2015, we raised concerns about the lack of adaptations to environment to make it more 'dementia friendly'. At this inspection we did not see that any further adaptations had been made to improve the environment for people living with dementia. The

Inadequate

Is the service effective?

registered manager told us they had sought advice and were in the process of considering colour schemes and replacing floor coverings. We highlighted that there were other simple measures that could have been put in place in the mean-time that had been discussed during the last inspection, such as putting people's photos on their doors if they were happy for this, and putting in place signage to aid with orientation around the home.

Requires improvement

Is the service caring?

Our findings

At our last inspection on 14 April 2015 we found the service had CCTV in place that was monitoring communal areas. The service had not consulted people living in the home on the use of CCTV and had not taken adequate steps to ensure people were aware of its presence. This was a breach of Regulation 10 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the provider was now meeting the requirements in relation to this regulation. The provider told us they had made the decision to turn off the CCTV within the communal areas inside the home. Cameras were still operating in areas accessed by people living at the home such as the garden and the lobby. However, none of the people living at Parkview we spoke with were aware of CCTV being in place. The registered manager told us these cameras were in place for reasons of safety and security.

We recommend the service reviews CQC information on the use of surveillance for health and social care providers.

People we spoke with told us they were treated with respect by the staff and that staff respected their privacy and dignity. One person said; "The staff show me respect when they assist me with anything I need. They knock on my bedroom door before coming in." We spoke with a relative who told us they found their family member to be treated respectfully. They said their family member was always well dressed when they visited. We spoke with a health professional who visited on a regular basis, who told us; "[Person] is generally well dressed and seems to like the staff."

The people we spoke with told us they got on well with the staff and found them approachable. One person said; "The staff are not bad and they treat me very well." Visitors we spoke with also told us they were made to feel welcome and found that staff were approachable. They told us there were no restrictions on visiting their family member. One relative we spoke with said; "The staff are easy to talk to and they are kind and caring."

Most of the interactions we observed between people living at the home and staff were respectful and friendly. However, at one point we observed a carer changing a person's top in the lounge area. This person showed some signs of distress whilst this was being done. However, there was no reassurance offered or other communication by the staff member. We observed the mid-day meal and saw one person needed to be observed by staff to ensure they consumed their food safely. Although this person was observed, the member of staff stood over them rather than sitting next to them, which could have provided a more discreet and personal experience for this person at lunch time.

We saw information was displayed around the home, such as the day of the week, activities for the day and a menu. One person told us the menu board was usually out of date. On the first day of our inspection we saw the main dish was as described on the board, although the accompaniments were different. People told us they were given information about the care they received and we saw there were copies of the service-user guide in some people's bedrooms.

Some people living at Parkview had a high level of independence. We saw these people were free to access the community and come and go as they pleased. We asked staff how they would support people to retain independence. One staff member said; "Lots are independent and we allow them to be." Another staff member told us they would encourage people to make choices, such as where they wanted to sit, or when they wanted to go to bed. One relative we spoke with told us their family member had made good progress since moving into the home and was building confidence and becoming more independent again.

One person was less positive about the support they received to be independent. They told us; "I used to go out and about by taxi whenever I felt like it but they are not keen on me doing that now." We confirmed with the registered manager that there was no legal reason such as an authorised DoLS that would mean this person could not go out when they wanted. On two occasions we also observed people being told or asked to sit down when they stood up. This meant people weren't being supported to access areas of the home freely when they wanted.

Two people living at Parkview and no visitors told us they had been involved in developing care plans. However, none of the people we spoke with expressed concern about this. One relative we spoke with told us the registered manager had discussed the care plan with them and that they were happy for the service to carry out the care planning without their direct input.

Requires improvement

Is the service caring?

We saw information on advocacy services was displayed. None of the people we spoke with were aware of what advocacy services were available, however, all told us they were able to speak for themselves or were able to contact a family member to help represent their views.

Requires improvement

Is the service responsive?

Our findings

During the mornings of the first two days of our inspection we saw that bowls of cereals had been set out in places on the table prior to people coming to the dining room for breakfast. Although we saw some people ate a cooked breakfast, we asked the registered manager how people were given a choice about what they ate for breakfast if the cereal was already set out. The registered manager when prompted stated that people living at the home chose what they had for breakfast. They said; "I know they have cereal every day." We asked how the registered manager knew that and how they would be aware if people had changed their minds. They confirmed they had not asked people, but said; "I know." This showed the lack of a person centred approach. One person told us; "I don't really have a lot of free choices as you just have to go along with the routine most of the time."

We saw care plans were in place for most people that covered areas including mobility, personal care, communicating, maintaining a safe environment and the person's medical history. There was some limited information in most people's care plans in relation to preferences around care as well as information on hobbies, interests and social needs. We found care plans were not always easy to follow and the writing was hard to read in many of the care plans. A member of staff also told us they found care plans hard to read.

There was evidence that most care plans had been reviewed regularly, although we found the information on support required was not always consistent with the support being provided. One person's care plan stated they needed assistance using a hoist to transfer, whilst the registered manager told us this person was able to mobilise with limited assistance and without a hoist being required. This meant staff that had read this person's care plan may not be aware of how to support them appropriately.

We looked at the care files for two people whom had moved to the home for short breaks (respite) care. There were respite admission assessments in place for each person, but not a full care plan. This was despite one person having been at the home for around six months. There was no record of hobbies, interests or preferences in either of these people's assessments. Although there was a copy of the local authority assessment in place for one person, the assessment the home had undertaken was incomplete. On this assessment there was no photo of the person, the 'likes to be called' section was blank and the personal inventory section was blank. Overall, six of the 23 boxes on the assessment plan had been completed. The care plan and risk assessment sections of this person's admission assessment were also blank.

This was a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to carry out an adequate assessment of needs and preferences.

We received a mixed response when asking people about activities. One person said; "I am not impressed with the activities. Good trips out are promoted and then cancelled." Another person told us; "They lay on an entertainer reasonably often and do some trips out."

We looked to see what activities were available to people living at the home, and saw a record of activities people had joined in with was kept. We saw several 'one to one' activities taking place such as members of staff playing card games and completing jigsaws with people. Another person was enjoying a game of dominoes with a member of staff. We also saw staff encouraging people to get out of their chairs for some exercise and did this through various ball games. Staff played music into the main lounge area and tried to encourage people to sing if they wanted to. The apprentices working at the home told us they had been given some responsibilities in relation to activities and we saw them interacting and engaging with people in a positive manner. One apprentice told us the service had introduced tablet computers to the home that they had downloaded apps such as word searches. They told us play-lists of music were also downloaded onto these and that the home had purchased wireless headphones to allow people to listen to music easily.

We asked the registered manager what was in place for younger adults living at the home. They told us one person went out and another did not want to do anything. One younger person living at the home told us; "There is stuff going on such as games. Not the kind of games I'm into. The karaoke is good."

There were, several missed opportunities for interaction with people who lived at the home. Whilst observing people in the main lounge area, on more than one

Requires improvement

Is the service responsive?

occasion we saw staff were sat in chairs next to people and did not attempt to engage them in conversation or interact in other ways. Although everyone told us staff were easy to talk with, three people told us staff did not seem to have much time as they were always busy.

We asked people what kind of choices they could make about their care and support on a day to day basis. People told us they were encouraged to go to bed by a certain time, but that they would not have to go to bed if they didn't want to. One person told us that staff told them when to get up in the morning. When asked if they could have a lie-in if they preferred they said; "They tell you to get up and dressed." Staff told us people could choose the times they went to bed or got up and one staff member gave an example of how a person had asked to stay in bed on the morning of our inspection and they had respected that choice.

The people we spoke with told us they would be confident to raise a complaint with a staff member or the registered manager if required. We looked at the service's record of complaints and spoke with one relative who had made a complaint. They told us appropriate action had been taken and that their concerns had been addressed. We saw there was one other complaint on file. There were handwritten notes on the print-out of the complaint that said there had been a 'personal meeting' with the person raising the complaint. However it was not clear from the records what the outcome of the complaint had been or what actions had been taken.

We saw there were feedback forms available within the reception area. There were also various surveys and questionnaires that had been completed on file. The surveys asked different questions and it was not clear how the service was analysing them or using findings to drive improvements. The registered manager told us that surveys would be looked at, and if there was anything that was justified or a complaint that action would be taken.

At our last inspection we raised that there had not been any recent residents/relatives' meetings. The records of meetings showed there had not been any further meetings since our last inspection in April. The registered manager told us relatives had said they didn't want meetings unless there was something important to discuss. Whilst the people we spoke with during the inspection did not express dissatisfaction with the frequency of meetings, we saw one of the complaints on file stated that the relative making the complaint would have liked to have raised the issues at a relatives' 'meeting, but that this was long overdue.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 14 April 2015 we found systems in place to monitor the quality of service provision at the home were inadequate. This was a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had not made the changes required to meet the requirements of this regulation.

We looked at the systems in place to ensure the quality and safety of service provision was effectively monitored. We saw audits were undertaken of care plans and medicines. However we had raised a concern at the previous inspection that other quality assurance checks were not in place to cover areas such as staff training, staff recruitment, infection control and observations of care practices within the home. We found that action had not been taken to put these checks in place.

The medicines audit was limited in depth and had not been effective at identifying the issues we found in this area. One of the questions on the audit related to 'when required' (PRN) protocols for medicines being in place. We saw the response on the audit indicated that such documents were in place when we in fact found they were not. The service had also not been following its documented policies and procedures in relation to the receiving and checking of medicines and administration of 'when required' (PRN) medicines. We looked at a document stating it was a 'spot check report' carried out for a member of care staff who administered medicines. This was based on the warning notice we issued to the service in relation to medicines. This was signed by a staff member to indicate they only gave medicines in line with 'when required' protocols. However, as these were not in place for the records we reviewed, this indicated the spot-checks were ineffective.

We found some staff working in the home did not have the required checks and documents in place in relation to their employment. Systems in place did not ensure staff were safely recruited following legal requirements and the service's own policy.

We found risk assessments to monitor the safety of the environment and care people were receiving were not always in place, suitable or up to date. The registered manager and director had failed to recognise or act in a timely manner in relation to known risks, such as those presented by the poor condition of the electrical system.

Care plans, risk assessments and other documents were difficult to read due to the legibility of the handwriting in them. We found records of food and fluid intake indicated low levels of fluid intake that staff believed had been recorded incorrectly. On the first day of our inspection we looked at one intake chart that indicated a low level of fluid intake and made the registered manager aware of our concerns. When we looked at the same record on the second day, the intake chart indicated a higher level of fluid intake and it appeared that some of the numbers had been altered. We asked the provider to investigate this and report back to us. They told us no-one at the service took responsibility for this action when questioned and stated the registered manager would provide training around record keeping.

These issues were a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have adequate systems in place to monitor the safety and quality of service provision, and did not maintain complete and accurate records.

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 had worked at the home for over 20 years and was also a registered nurse. Following our last inspection the service had sought the services of an external professional who was working with the registered manager on a part-time, temporary basis. This was to help address certain shortfalls we had previously identified around safeguarding and seeking consent.

During the inspection we identified wide-ranging concerns about the quality and safety of the service as identified in this report. Some of the issues identified during our last inspection had not been effectively addressed. Many of the concerns we had related to the effective management and leadership of the service. When providing feedback about

Is the service well-led?

the issues we found during the inspection, we found that the external professional was responding to our concerns and identifying potential ways to reduce risks rather than the registered manager or director.

We asked what training and development activities the registered manager had undertaken to ensure they were aware of current best practice and had the skills required to effectively manage the service. The registered manager told us they did not have a continuous professional development log, but that they regularly read nursing and management journals. The training matrix indicated the registered manager had undertaken training in safeguarding, fire safety, dementia and DoLS. However, as discussed in the 'safe' section of this report, the registered manager was conducting the medicines round and this is an area where we found poor practice. The registered manager told us they had received medicines training as part of their nurse training, however there was no evidence of any recent training in medicines administration or that the registered manager's competency had been assessed.

The registered manager also told us they instructed staff how to complete moving and handling tasks, and we also saw they were actively involved in supporting people with moving and handling. There was no evidence that the registered manager had received training in moving and handling, and this was also an area where we identified poor practice. The registered manager confirmed they had not had training 'for a long time' and stated they learned a lot through reading, experience and taking instructions from visiting healthcare professionals.

The issues in relation to the competence and skills of the registered manager were a breach of Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the service was displaying the rating from their last inspection at the home. However, we looked at the website for the service and saw the rating was not being displayed as is a legal requirement. We made the provider aware of the requirement to display their rating in June 2015 and provided a link to the CQC guidance. We wrote to the registered manager and director again in August 2015 to remind them of the requirement. During the inspection the director showed us an email that had been sent to the website provider to request that the changes were made to display the rating. We set a deadline for the rating to be properly displayed and the provider met this deadline.

Staff and visitors we spoke with were positive about improvements that had been made since our last inspection. There were comments that there were now more staff around during the day and that improvements had been made to the environment, including the cleanliness of the home. We saw there was a notice displayed in the home informing people of actions being taken to improve the environment. This included the replacement of floor coverings, furnishings and replacement of the windows. Most staff told us they thought the service was well-led, although two staff were not certain that any ideas they had would acted upon. One member of staff told us they thought the registered manager did not like change and that they took on too much.

Most of the relatives we spoke with during our visit told us they found the registered manager and director were easy to approach and would listen to any concerns they may have. However, one visitor told us they didn't feel they could talk with the registered manager. We saw the registered manager was approachable to visitors and spoke frequently with them throughout our inspection.

The registered manager told us the service had started to hold regular 'flash meetings' with staff, and staff confirmed they had attended these meetings. They told us these were held to update staff about any important developments about the service and people living at the home. We looked at records of these meetings and saw topics such as CQC's last inspection report and safeguarding had been discussed.

We reviewed the service's 'statement of purpose'. This is a document services are required to submit to CQC, which contains a required set of standard information about the kinds of service provided and details about the location. It is a requirement that the registered person regularly reviews the statement of purpose to ensure it is up to date and notifies the CQC of any changes. The statement of purpose for Parkview stated the service was no-smoking when this was not the case, and stated there was a separate 'quiet lounge'. We found this room had been converted to a bedroom. We found the service was providing a service to people with support needs in relation to mental health and misuse of drugs and alcohol. The

Inadequate

Is the service well-led?

statement of purpose did not indicate that a service was provided to people with these support needs. We asked the provider to submit an updated statement of purpose to us by a set deadline.