Parkview Care Homes Limited

# Parkview Care Home

**Inspection report**

70 Old Shoreham Road Hove,
BN3 6HJ
Tel: 01273 720120

Date of inspection visit: 7 December 2015
Date of publication: 11/01/2016

## Ratings

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

## Overall summary

We inspected Parkview Care Home on the 7 December 2015. Parkview Care Home is a residential care home that provides care and support for up to eight people living with past and present mental health needs. On the day of the inspection, eight people were living at the home. The age range of people living at the home varied between 40 –80 years old. Predominately people required support with their mental health, support was also needed in relation to self-harm, diabetes, anxiety and physical healthcare needs.

Accommodation was provided over four floors. Stairs connected all floors. Everyone living at the home could safely use the stairs. Located in Hove, the home provided access to the city centre and seafront. There was good access to public transport which was regularly used by people living at Parkview Care Home. During the course of the inspection, people were seen coming and going independently, going out with staff and family.

People spoke highly about living at the home. One person told us," It's nice and quiet and everyone gets on well here." Another person told us, "It's a safe environment." A third person told us, "I enjoy it here." Staff also spoke highly of the home. One staff member told us,

# Summary of findings

"There is a sense of a family atmosphere here and the variety of staff is really good. They are flexible and do everything from cooking to caring and interacting with residents."

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.

Quality assurance systems were in place to review and monitor the effectiveness of the home. However, these systems were not yet fully embedded or completed. Incidents and accidents were not monitored or audited for any emerging trends, themes or patterns. Staffing levels were sufficient and no significant concerns were raised regarding staffing levels. However, robust systems were not in place for determining, assessing and reviewing that two staff members were sufficient to meet the needs of eight people living with past and present mental health needs. In relation to the above concerns, we have therefore asked the provider to make improvements.

The recovery model was fully utilised and people were encouraged to regain their independence. Support was provided to enable people to cook independently, do their laundry and self-administer their medicines independently. One staff member told us," We try to give people the tools to empower themselves, enable them to recover and improve their daily lives."

Staff received training to help them undertake their role and were supported through regular supervisions and appraisals. Staff had training in working with the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Training specific to mental health was also provided and staff spoke highly of the training provided. One staff member told us, "The training is good. We are encouraged to do specialist training and any other subject related to our work which we have a special interest in. I came out feeling inspired after the physical intervention training day."

Safe recruitment procedures were followed and appropriate pre-employment checks had been made including evidence of identity and satisfactory written references. Appropriate checks were also undertaken to ensure new staff were safe to work within the care sector.

Training schedules confirmed staff members had received training in safeguarding adults at risk. Staff knew how to identify if people were at risk of abuse or harm and knew what to do to ensure they were protected.

People were supported to make sure they had enough to eat and drink and their nutritional needs were met to ensure they stayed healthy. Lunch time was a sociable event where staff and the registered manager joined people, eating together discussing various topics. Any special dietary requirements were met and action was taken if people were losing weight. Menus were devised in partnership with people and were changed every four weeks.

Medicines were stored, administered, recorded and disposed of safely. Staff were trained in the safe administration of medicines and kept records that were accurate. People were also supported to self-administer their medicines independently.

Staff recognised the signs of when someone's mental health may be deteriorating. One staff member told us, "We recognise that someone is deteriorating mentally if they become agitated, tearful, stay in their rooms or neglect themselves and will arrange a review of their care." Communication was valued and staff and the registered manager recognised the importance of effective communication in supporting people to remain well.

# 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?**

Good

Parkview Care Home was safe. People told us they felt safe living at the home. Risk assessments provided detail and sufficient guidance to safely manage people's mental health needs. A positive approach to risk was adopted. Staff had received training on adult safeguarding and proactively recognised when a safeguarding concern needed to be raised.

Medicines were stored safely and people were enabled to self-administer their medicines. Guidelines were in place for ordering, recording and disposal of medicines.

Recruitment practice was safe and staff of the right calibre was employed. Staff understood what to do in the event of an emergency.

**Is the service effective?**

Good

Parkview Care Home was effective. People felt staff had a firm awareness of their mental health needs. Staff also recognised that people's physical healthcare needs should not be overlooked. Staff received training which enabled them to carry out their job roles effectively.

The principles and implementation of the Mental Capacity Act 2005 (MCA) were well understood and put into practice. This helped ensure people's rights were protected.

People were encouraged to be independent with cooking. Support was also provided to ensure people received a healthy diet. Access to food and drink was available throughout the day.

**Is the service caring?**

Good

Parkview Care Home was caring. People had positive relationships with staff that were based on respect. People were treated with dignity and their confidentiality was respected. Staff spoke with kindness and compassion for the people they supported.

There was a calm, friendly and relaxed atmosphere throughout the home. Mechanisms were in place to involve people in their care and treatment and in the running of the home.

**Is the service responsive?**

Good

Parkview Care Home was responsive. People were supported to participate in meaningful activities and support was provided to encourage people's inclusion in the community. Communication was seen as key in providing effective and responsive mental health care.

A complaints policy and procedure was in place. People felt able to raise any issues or concerns and were confident their concerns would be acted upon.

# Summary of findings

The recovery model in mental health was utilised and people were supported with promoting their independence and to move on from Parkview Care Home.

**Is the service well-led?**

Parkview Care Home was not consistently well-led. Improvements were required to the home's quality assurance framework. Formal systems were not in place for determining staffing levels or monitoring incidents and accidents.

People and staff spoke highly of the registered manager and their leadership style. The registered manager was clear about their roles, responsibility and accountability and staff felt supported by the manager

The home operated in a culture of honesty and transparency.

**Requires improvement**

# Parkview 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. 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 was an unannounced inspection on 7 December 2015. It was undertaken by two 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 service. During the inspection, we spoke with seven people who lived at the home, four members of staff, cleaner and the registered manager. Before the inspection, we checked the information that we held about the home and the provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the home. A notification is information about important events which the home is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the PIR to help us focus on specific areas of practice during the inspection. Parkview Care Home was last inspected in December 2013 when no concerns were identified.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, three staff files along with information in regards to the upkeep of the premises. We also looked at four care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at Parkview Care Home. This is when we looked at their care documentation in depth and obtained their views on how they found living at Parkview Care Home. It is an important part of our inspection, as it allowed us to capture information about a selected group of people receiving care.

Good

# Is the service safe?

## Our findings

People told us they felt safe living at Parkview Care Home and their individual mental health needs were met. One person told us, "It's a safe environment." Another person told us, "I feel safe and I'm very happy." A third person told us, "There is no bullying here."

Medicines management was appropriate, effective, safe and medicines were stored correctly. Medicines were ordered in a timely fashion from the local pharmacy and Medication Administration Records (MAR) charts indicated that medicines were administered appropriately. MAR charts are a document to record when people received their medicines. Records confirmed medicines were received, disposed of, and administered correctly. People were prescribed 'as required' (PRN) medicines and there were clear protocols for their use. PRN medicines can be prescribed for people with mental health needs to manage levels of anxiety, behaviour that challenges or periods of anxiousness. Where people were prescribed a PRN medicine to manage their mental, the PRN protocol included guidance on the steps to take before administering the medicine, the expected outcome and the circumstances for reporting any concerns to the GP.

Covert medicines were used within Parkview Care Home. Covert is the term used when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, in food or in a drink. Covert medicine is sometimes necessary and justified, but should never be given to people who are capable of deciding about their medical treatment. The covert administration of medicines should only take place within the context of existing legal and best practice frameworks to protect the person receiving the medicines and the care staff involved in giving them. Where people were administered covert medicines, guidance was in place to demonstrate the decision was made in line with legal requirements as set out by the Mental Capacity Act 2005 and the person was unable to make a decision regarding their medicine. A best interest decision had been made in collaboration with the GP, pharmacy, registered manager and the person's representative which was reviewed regularly. The review considered when the person was last encouraged to take their medicines, what other options of medicine administration had been considered, in what ways the medicines were essential and in the person's best interest and what the desired outcome was.

Helping people to look after their own medicines is important in enabling and promoting people's mental health recovery. Some people self-administered their medicines while others were supported to regain more and more independence with their medicine regime. The registered manager told us, "To help people move on, the pharmacy sends some medicines in a weekly pack which we then give to the person to enable them to self-administer their medicine on a cycle basis and we then do spot checks to see how they are getting on. Where people are in the process of self-medicating, we start with giving them one day's worth of medicine to self-administer, then increase this to three days than a week." Where people were self-medicating, a robust risk assessment was in place.

Systems were in place to identify and report concerns about abuse or poor practice. Staff had received training in adult safeguarding and demonstrated knowledge of how to raise a safeguarding concern in line with the Care Act 2014. One staff member told us, "Abuse could be financial, verbal, sexual or neglect. If someone made a disclosure I would explore the issue with them, then report it to the manager who would speak to the resident and raise a safeguarding concern." Following changes to legislation in April 2015, self-neglect is now deemed a form of safeguarding. Self-neglect is a challenging area of practice, balancing the rights of the person against their right to self-determination. A failure to engage with people who are not looking after themselves, whether they have mental capacity or not, can have serious implications for the health and well-being of the person concerned. The registered manager and staff had recognised that where people were self-neglecting, this needed to be considered under the safeguarding arena. The registered manager, "Where people are self-neglecting, we inform them of the changes in legislation and that we may need to raise a safeguarding concern." Staff and the registered manager told us of how they worked in partnership with people who self-neglected, supporting them to clean their room and explore any hoarding behaviour. Weekly room checks took place to ensure the risk of self-neglect was being managed.

Good

# Is the service safe?

Risk assessments and risk management is an integral part of good quality mental health care. Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused. Each person had their own individual risk assessments in place which considered self-harm, fire safety, challenging behaviour, financial vulnerability and managing violence. Where people were at risk of financial vulnerability, measures were in place to safeguard those people. For example, some people had deputies under the Court of Protection to manage their finances. Where people had deputies in place, money was dispensed to Parkview Care Home and staff purchased items on behalf on the individual or provided them with a set allowance daily. A clear audit trail was maintained when staff held people's money. Records reflected how much were given to the person, the remaining balance and was signed by two staff members and the person. The registered manager confirmed that at the end of each day the documentation was checked to ensure the balance tallied.

Where people self-harmed, risk assessments were in place providing guidance and actions for staff to follow. These included ensuring the person had a regular supply of saline and dressings to manage their wounds. They also ensured the person had a sharps bin in their bedroom and a yellow clinical waste bag (so they could dispose of their contaminated dressing). Staff also needed to check their blood drainage bowl under their bed to see if it needed to be disinfected or they required a new one. The risk assessment also included for staff to be vigilant in monitoring for any signs of dry or fresh blood. If staff saw any blood they were to sensitively approach the person to see if they needed any help and if they had enough saline and dressings.

A positive approach to risk taking was adopted by staff and the registered manager. Positive risk taking was defined as, 'weighing up the potential benefits and harms of exercising one choice of action over another.' The registered manager told us, "We encourage people to take positive risk as it helps with promoting their independence and promoting them to move on." Staff told us how they worked in partnership with people to promote them to take positive risks by self-administering their medicines, cooking and going out and about independently. One person told us, "I have the freedom to come and go." Staff told us of one scenario whereby a person suffered a fall and their confidence had been knocked and they became frightened to go out alone in-case they had another fall. Following the fall, staff went out with the person and slowly worked with them to rebuild their confidence. On the day of the inspection, we saw that the person was now confident enough to go out alone.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview and before they started work, the provider obtained references and carried out disclosure and barring service (DBS) checks. DBS checks helps employers make safer recruitment decisions and prevent unsuitable people from working with the people they care for. As part of the interview process, the registered manager told us, "A key question we ask at interview is staff's understanding of mental health. Mental health can affect anyone and I feel it's important we recruit staff that understand this."

Staffing levels consisted of two staff members during the day and night, with the registered manager on site five days a week and support from a deputy manager. Throughout the inspection, the home presented as calm and relaxed. People were seen coming and going and staff were seen spending one to one time with people and taking people out to the local shops.

Consideration had been given to what to do in the event of an emergency. A business continuity plan was in place which detailed the actions to take in the event of flooding, loss of heating or electrical failure. Staff were clearly able to describe what action they would take in the event of an emergency such as a fire. One staff member told us that separate responsibility was devolved to staff to call the fire brigade and do everything possible to limit its spread while another was responsible for evacuating the home. The provider notified us of a fire incident they experienced earlier in the year. Staff told us how they were complimented by the fire brigade on their speedy response to the fire and for evacuating everyone in a safe and timely manner.

Good

# Is the service effective?

## Our findings

People commented they felt confident in the skills of staff member. One person told us, "Staff listen to me." Another person told us, "Staff are nice and always listen to me." Staff received essential training to support them to effectively meet people's mental health needs.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support the needs of people living with mental health needs. The provider operated an effective induction programme which allowed new members of staff to be introduced to the running of Parkview Care Home. New members of staff were completing the Care Certificate induction programme. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Designed with care workers in mind, the Care Certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. New staff confirmed they undertook a period of shadowing experienced staff and did not work alone until they had been assessed as competent to do so.

The importance of a strong skilled workforce was recognised by the provider and registered manager. Training schedules confirmed staff received mandatory training and specific training to help staff meet people's individual needs. Recent training included; schizophrenia, self-injury and physical intervention training. One staff member told us, "There are a wide variety of training opportunities here and we can go on any courses we are interested in." Another staff member told us, "The training is good. We are encouraged to do NVQs (national vocational qualification) and specialist training and any other subject related to our work which we have a special interest in. I came out feeling inspired after the physical intervention training day." Staff career progression was encouraged and staff were supported to obtain further qualifications. Two staff members had signed up to undertake the health and social care level two and three diploma and one staff member had just completed the Northern Council of Further Education (NCFE) level two Understanding Mental Health Awareness and had now enrolled onto their Common Health Conditions course.

Staff told us that they received good day-to-day support from work colleagues and formal supervision at regular intervals. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Regular supervision provides an insight into what the role of the person being supervised entails, the challenges they face and what support they need. It is an aspect of staff support and development. Staff spoke positively of supervision and commented they felt valued as employees. One staff member told us, "Supervision is good. We can speak openly with the manager and we receive positive feedback as well as constructive feedback on our work". Another staff member told us, "Supervision is really, really important. I can be honest and clear with him (the manager) and it's not only about my concerns but also about his ideas about ways I can improve." A third staff member told us, "Supervision is good. We are encouraged to talk about the little things and it makes work much easier."

People were able to make choices about what they wanted to eat. Staff liaised with people about what they wished to eat for breakfast, lunch and supper. Menus were devised in partnership with people at residents meetings and the menu changed every four weeks. One person told us, "I think the food is good." Another person told us, "The food is freshly cooked."

As part of the ethos of recovery, people were encouraged and supported to regain their independence with cooking. Some people cooked their own snacks and made their own hot meals. Weekly cooking classes also took place to help empower people's independence with cooking. One person told us, "I am eating more healthily." The registered manager told us, "Staff cook all the meals here and we encourage people to be involved in the cooking of the meals. Risk assessments are in place but we are lucky to have a kitchen which allows for people to be fully involved in cooking." We spent time with people during lunchtime. People were involved in laying and setting the dining room table ready in preparation for lunchtime. The registered manager and staff also joined people for lunch, creating a sociable atmosphere. People chatted together and later took their own plates into the kitchen and brought out their own dessert.

Any nutritional needs were acted upon and met. Some people required a special diet, due to religious reasons, some people were vegetarian and some people required a diabetic diet. The registered manager and staff recognised that due to some people's mental health needs, they may

Good

# Is the service effective?

not recognise they are diabetic or deny they are diabetic. Staff therefore worked in partnership with the diabetic dietician and devised a menu based on the input received from the dietician. Risk assessments and care plans were in place to manage diabetes. Staff members demonstrated a firm understanding that poor management of diet could lead to poor uncontrolled diabetes. Guidance to manage the diabetes included for staff to limit one person's number of bacon sandwiches to three times a week. Ensuring the person had both carbohydrates and protein. The menu Offered pureed cooked apples mixed in rice pudding and added grated carrots/courgettes in sauces to increase vegetable/fibre intake.

People felt staff were effective in managing their healthcare and mental health care needs. Staff recognised that although people required support with their mental health, support was also required to ensure people's physical and health care needs were met. Staff supported people to access GP appointments and opticians also visited the home to undertake eye tests for people. One person told us, "I have a yearly check up with the GP." Another person told us, I've been referred to the local dentist." Documentation was maintained which recorded when people had seen the GP, chiropodist, dentists and practice nurse. Care plans included clear guidance on people's physical care needs along with the signs and symptoms for staff to look out for. For example, one person was prone to chest infections, erratic eating behaviours and complaints of pain. Guidance was in place for staff which included if they noticed any of the following; person complaining of pain in their legs, sore throat, difficulty breathing, losing weight or stopped eating. The guidance advised staff to record and inform the manager if they noted any of the indicators.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Training schedules confirmed staff had received training on the MCA 2005. Staff told us they always asked for people's consent before providing care, explained the reasons for the care and gave them time to think about their decision before taking action. Where required, mental capacity assessments were completed which considered specific decisions and were completed in line with legal requirements. For example, one mental capacity assessment was completed which was to assess whether the person had insight into their dietary needs. The mental capacity assessment found the person could retain the information, communicate and understand the information. But was unable to weigh up the information, therefore lacked capacity to make that specific decision.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS is for people who lack the capacity to make decisions for themselves and provides protection for people ensuring their safety and human rights are protected. On the day of the inspection, one person was subject to a deprivation of liberty safeguard. Staff were aware of who was subject to a DoLS and what that meant for that individual. As part of the DoLS, the registered manager had also completed a best interest checklist which listed the proposed intervention as part of the DoLS. For example, as part of the DoLS, staff kept the person's allowance and cigarettes. Every hour staff gave the person their cigarettes. The best interest checklist considered if there were least restrictive options to consider. Documentation reflected that the person was asked to look after their own cigarettes but they declined. Staff also identified that if the person did agree to looking after their cigarettes it would increase the risk of them smoking all their cigarettes at once and increase the risk of them smoking in the home.

Good

# Is the service caring?

## Our findings

Caring relationships had developed between staff and people. People spoke highly of staff and the support they received. One person told us, "The staff are kind and caring." Another person told us, "The manager is caring." A third person told us, "Staff are relaxed and easy to talk to."

The atmosphere in the home was calm and relaxing. Staff and the registered manager recognised the importance of maintaining a calm environment which promoted mental health recovery. The registered manager told us, "We consider the environment and whether it is inclusive to mental health and supporting people to move on. A couple of years ago, the home was re-painted with calmer colours to help create a soothing atmosphere. The carpets were also replaced to help promote an inclusive environment." Staff and the registered manager also recognised that Parkview Care Home would be some people's home for life, therefore it was important they felt comfortable and at ease. People were encouraged to treat the home as their own and throughout the inspection, we saw people opening the front door, coming and going and spending time how they pleased.

With compassion, staff spoke highly of the person they supported. Staff were able to tell us about the times people liked to get up, how they liked to spend their time, what activities they enjoyed and their preferences in respect of meals. They also knew about their families, friends, personal history and their interests. Staff told us about one person who enjoyed reading newspapers, discussing current affairs, spoke French and was interested in learning Spanish. Throughout the inspection, staff interacted with people in a warm and friendly manner and treated people with kindness and compassion. People and staff laughed together, they spent time listening to them and responding to their questions and explained what they were doing and offered reassurance when anyone appeared anxious.

People's equality and diversity was upheld and respected. Staff recognised people for their individuality and personality. People were called by their preferred name and it was clear staff had spent considerable time building rapports with people. One staff member told us, "One person has the best sense of humour, they are every so funny." Staff and the registered manager were involved with a local LGBT (lesbian, gay, bisexual and transgender) forum. A LGBT champion had been nominated and the registered manager told us, "We are the only residential care home to be attending the LGBT forum. I feel it is important that as a home we are more inclusive to LGBT people and promote awareness around LGBT rights in care homes."

The principles of privacy and dignity were upheld and embedded into everyday care practice. Staff were able to describe how they maintained people's privacy and dignity by knocking on doors and waiting to be invited in. They made sure doors were closed and the person was covered if they were assisting them with personal care. One staff member told us, "We always knock on their door and wait to be invited in. We find a private space to talk where they feel comfortable and safe and don't discuss their concerns with other residents." People confirmed staff upheld their privacy and dignity. One person told us, "Staff knock before entering my room."

People were encouraged to treat their rooms as their own. People held their own keys to their bedroom and could lock their own room. People told us they appreciated being able to lock their room and have their own privacy when required. With pride one person showed us their bedroom. They told us they could bring their own furniture if they so wished, but they enjoyed having their belongings around, including their photographs and books. They showed us their photographs of their family and commented they enjoyed having their own space.

Measures were in place so people were consulted about the care and treatment they received and what they wanted to do. Each person had an individual key-worker who was responsible for overseeing their care plan and involving the person in their care plan. People confirmed they felt able to approach staff and staff listened to. One person told us, "I get on with the staff and they listen to me." Mechanisms were also in place to involve people in the running of the home. 'Resident meetings' were held on a regular basis. These provided people with the forum to discuss any concerns, queries or make any suggestions. 'Resident meetings' were held on a monthly basis and the minutes of these were circulated to all the residents in the home. Minutes from the last meeting reflected that the idea of a clothes party was discussed along with the best place to get a takeaway. People commented they found of resident meetings helpful. One person told us, "They ask us if we like the food at the 'residents meeting'." Another person told us, "They ask us if we want to go places at the 'residents meeting'."

Good

# Is the service responsive?

## Our findings

The registered manager and staff promoted a person centred culture. One person told us, "I do love it here." People's independence was promoted and the recovery model of mental health was utilised. Staff responded to people's needs in a responsive and personalised manner and clearly recognised the triggers which indicted a person's mental health needs were deteriorating.

People's care and support was planned proactively in partnership with them. The model of recovery was utilised in supporting people and planning their care and support in partnership with them. The recovery model in mental health refers to supporting a person to move forward. 'For some people this can be about returning to a state of feeling well and content, for others it can be about rebuilding their life after a period of illness and understanding more about how to manage problems related to their health and lifestyle'. The registered manager told us, "We focus on recovery and rehabilitation. We want to promote independence and support people to move on. We recognise that for some people this is their home for life, but for others, there is a personalised move on care plan and we work in partnership with people and external professionals such as psychiatrists and care coordinators to enable people to move on." Each person had their own recovery and move on plan which considered how to promote the person's independence and what their individual move on plans may be. For example, one person's recovery care plan identified they moved from supported accommodation to Parkview Care Home with the view to develop their rehabilitation skills and move back into the community. Staff told us that since moving into the home, they identified that the person's care needs were increasing and their cognitive ability was deteriorating. Their recovery plan later identified that it was unlikely the person would be able to live in supported living again. However, staff recognised that the person had moved throughout their life and identified that moving was part of their identity, so they were supporting the person to look at alternative care homes whilst promoting their independence as much as possible.

Staff recognised the importance of working in the model of recovery and promoting people's independence. One staff member told us, "We encourage people to be independent. They help out in the house, set the table, look after their personal needs, do their own laundry with assistance, socialise with others and do activities they enjoy." Another staff member told us, "I try and encourage people to do things for themselves and always praise them when they do it". One person told us how they were supported to become independent and valued their independence. They commented, "I do my own shopping and I'm quite independent."

Staff were flexible and responsive to people's individual mental health needs. Staff clearly recognised the triggers of when someone's mental health needs may be deteriorating. One staff member told us how if one person stops taking their prescribed medication that could be a trigger that their mental health was deteriorating. Another staff member described triggers including one person was speaking loudly to their voices, or another person knocking their head on the wall. Where staff identified triggers in people's mental health, they took responsive action. Reviews with psychiatrists and care coordinators were organised to help prevent a hospital admission and prevent the person's mental health from deteriorating further.

Communication and engaging with people with mental health needs was an essential component of all therapeutic interventions Different systems were utilised to ensure information was shared effectively and communication was at the heart of the service. Handovers took place between each shift. This enabled new staff coming onto shift to be aware of any concerns, if people had any appointments or people were feeling unwell. We observed the afternoon handover and noted that all staff members contributed and discussed the well-being of every person including their food intake, together with any concerns and issues which could influence the care they needed during the next shift. Staff spoke highly of communication and handovers. One staff member told us, "Handovers have always been pretty good. We can discuss things there so we can get a consistent approach to our residents." Another staff member told us, "Handovers are really, really important. The team has to be kept informed and we can express our concerns about people and discuss our different ideas, working together for the benefit of the residents."

Engagement with meaningful activities helped make people feel valued, develop new skills and promote identity. For people with mental health needs, engagement

Good

# Is the service responsive?

with activities can provide structure and promote well-being. One person told us, "There are lots of activities." Another person told us, "There are lots of activities like coffee morning and walks and games." The registered manager told us, "We have a programme of activities but also try and engage people in activities meaningful to them." The registered manager told us how the home had recently got fish and turtles as one person had a passion for fish and they had taken on responsibility for feeding these.

To reduce the risk of social isolation and promote engage, people had individual social isolation and promoting therapeutic activities care plans. Care plans identified when people were at heightened risk of social isolation and included guidance for staff to follow to reduce social isolation as much as possible. For example, one person was at significant risk of social isolation due to high levels of anxiety, paranoia, delusional beliefs, mistrust of others and xenophobia. To help alleviate the risk of social isolation, actions were in place for staff to follow. These included engaging with the person on topics they enjoy. Staff were guided to support the person with their 'thoughts, feelings and experiences that cause them to avoid others and self-isolate, offering gentle challenges and alternative realities to their beliefs which perpetuate this tendency'.

On the day of the inspection, a cake and coffee event was held. Staff went to the local shops with people and prepared cake with a pot of coffee or tea. People gathered in the communal lounge along with staff. Together they discussed various topics and a social environment was created where staff and people interacted about topics they enjoyed. Staff and the registered manager focused on creating a sociable atmosphere whereby staff and people enjoyed one another's company. Regular social events included weekly pub lunch outings, group breakfast, weekly roast dinners where people all helped in the preparation, going to the local café for tea and cake and afternoons for baking cakes. The registered manager told us, "We focus on meaningful activities but also activities which involve people and get everyone together." The registered manager also engaged with the local community and various projects in the community. For example, through engaging with a local organisation, some people from Parkview Care Home were now attending external events held by these organisations. The registered manager told us, "Some people are going to a Christmas event tomorrow, our staff are taking them and there will carols, mulled wine and mince pies." In conjunction with the Parkview Care Home sister care home (care home under the same provider), people also participated in a Christmas pantomime and would be showing the pantomime to the care staff at both Parkview Care Home and the sister care home.

People told us they felt listened to and staff responded to their individual needs. People confirmed if they were not happy about something, they could approach their key-worker or the registered manager. One person told us, "I can raise concerns with the manager." People were made aware of the complaints system when they moved into the home and a copy of the complaints policy was also displayed on a notice board. Staff commented they had actively supported people to raise any concerns and make a complaint. Since January 2015, the provider had received 15 complaints, most of which had been verbal. Documentation provided an overview of the complaint, how the complainant would like the complaint to be resolved and the action taken. Documentation confirmed the complaint had been handled in the timeframe set out in the complaint policy and feedback, including an outcome where it was possible, was given to the complainant.

Requires improvement

# Is the service well-led?

## Our findings

People and staff spoke highly of the leadership style of the registered manager. One staff member told us, "The manager is great. He is the best manager I have ever had. He is approachable and understanding." Another staff member told us, "The manager makes time for residents and staff. He makes every member of staff feel they make an important contribution to the successful running of the home." Although people spoke highly of the registered manager, we found areas of practice which were not consistently well led.

Following an incident and accident, documentation was completed which looked at where it occurred, the date and time, who was involved, witnesses, what happened prior to the incident, during and after. However, mechanisms were not in place to monitor incidents and accidents on a regular basis to help identity any emerging trends or themes, such as if people were having altercations or becoming aggressive at certain times of the day. Under the Care Act 2014, providers and registered managers are required to have systems and mechanisms in place to enable them to identify patterns or cumulative incidents. The registered manager told us, "I don't formally audit the incidents and accidents, but this is something I plan to do." We have therefore identified this as an area of practice that needs improvement.

Systems were in place to monitor the running of the home and the effectiveness of the systems in place. However, these were not fully embedded into practice or completed. The provider had devised a quality assurance audit based on the Care Quality Commission's five key lines of enquiry. The audit considered each key line of enquiry and then the additional prompts under the key lines of enquiry. For each key line, the audit considered whether they were meeting it, what they did well and what the service could do better. For example, under caring, the audit had identified that for people without any relatives, they could be referred to an advocate. However, there was no date for completion of this action. The audit also hadn't been completed, therefore a clear picture could not be provided on how the service was meeting the five key lines of enquiry and how they were assessing the effectiveness of the delivery of care and support.

The absence of a formal quality assurance framework had no direct impact on the quality of care provided. People commented they felt able to approach the management team and received the care they needed. However, a robust quality assurance system was not in place to identify where quality or safety was being compromised and how to respond without delay. We have therefore identified this as an area of practice that needs improvement.

People and staff raised no significant concerns regarding the number of staff deployed. Some staff members felt an additional person to help with activities from time to time could be beneficial. However, staff confirmed they never felt rushed and had sufficient time to support people. We asked the registered manager what systematic approach to determining staffing levels was in place. The registered manager told us, "A dependency tool isn't in place, but I always increase staffing levels if someone is unwell or it is felt additional staff is required." The registered manager confirmed that the staffing levels of two staff at all times had been in place for many years. We questioned how it was determined, assessed and reviewed that two staff members was sufficient to meet the needs of eight people with present and past mental health needs. We have therefore identified this as an area of practice that needs improvement.

There was a management structure in the home which provided clear lines of responsibility and accountability. Staff members were aware of the line of accountability and who to contact in the event of any emergencies or concerns. Staff members spoke positively about the leadership and management style of the registered manager. The registered manager provided leadership five days a week. A deputy manager also provided support and guidance. One staff member told us, "The manager is lovely. You can go to him with anything and he will help you if he can." Another staff member told us, "The manager has always got time for everyone." People also spoke highly of the registered manager. One person told us, "I like the manager." Another person told us, "The manager is a good guy."

An open and transparent culture was encouraged by the registered manager. Staff confirmed they worked collaboratively and approached their work as a team. Staff also confirmed there was an open culture in the home and any suggestions they made for improvement were considered seriously. For example, one staff member told us how one person had not been receiving their full dose of inhaler as they had difficulty in judging the time required to

Requires improvement

# Is the service well-led?

use it. They suggested for the staff member administering the medicine to count slowly up to ten during the inhalation and the person was now receiving the full dose to good effect.

The ethos of the home was embedded into practice and staff spoke highly of the home. One staff member told us, "This is a nice place to work. It's like a second home and the residents are amazing." Another staff member told us, "The team works well together. The members of the team communicate well and any tensions are addressed and I have never had a problem with the team. They are all professional and we help each other out."

There were systems and processes in place to consult with people and staff. Both staff and 'resident' meetings were held on a regular basis. These provided people with the forum to raise any concerns, discuss ideas and practice issues. Minutes from the last staff meeting in November 2015 reflected that health and safety, record keeping, activities, employment issues, plans for development and matters relating to the residents were discussed. Satisfaction surveys were also sent out via the provider and people completed these online anonymously. Feedback was then sent to the provider for analysis. Feedback from a recent satisfaction survey included, 'The staff are Parkview Care Home are caring, the management is good' and 'I like the company, the staff and the residents including the manager. I like the building and the facilities. I like care, I have my freedom and I like the garden.' Another comment included, 'I enjoy living here because I have my en-suite bathroom which is very convenient. I have a bath every night. It is nice having a garden with new furniture and I can have my meals in the garden in summer. I can make my hot drinks. I like the manager and the staff. I get on very well and I have my own freedom.'