Viewpark Care Home Ltd

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Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 8 and 9 August 2017 and was unannounced.

We last inspected this service on 23 November 2016 when we identified multiple breaches of the regulations, rated the service as inadequate overall and placed the service in special measures. At this inspection we found some limited improvements had been made, and the service was meeting the requirements of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to breaches relating to the display of their rating, safeguarding and deprivation of liberty safeguards (DoLS), and dignity and respect. However, we identified ongoing and serious concerns in relation to the provision of safe care and treatment, assessing and acting to reduce risks to people's health and wellbeing, the safe management of medicines, care planning and assessment, safe staffing, governance and records. We also identified a new breach of the regulations relating to failure to notify the CQC of a serious injury. We are currently considering our options in relation to enforcement and will update the section at the back of this report once any enforcement action has concluded.

We have made one recommendation in this report. These relate to following the Mental Capacity Act code of practice and associated guidance.

Viewpark Care Home Limited is a purpose built residential care home registered to provide care and support to 27 older people. There were 26 people living in the home on the day of our inspection. Bedrooms are located on two floors, with two lifts and two staircases between the floors. There are two dining rooms, three lounges, and a conservatory. The home is situated in a residential area of Moston in north Manchester.

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 identified concerns with the way the service identified and managed risks to people's health and wellbeing. Risk assessments were not always up to date and staff were not always acting on the advice of professionals. For example, staff were not following advice in relation to one person's dietary requirements, which put them at risk of choking.

The service had introduced a new electronic medicines management system. However, we found people had not always received their medicines as prescribed. Checks of medicines had not identified or ensured timely actions were taken to address any potential medicines errors. We also observed staff did not always follow safe and hygienic practices when administering medicines.

We observed that people received support promptly when they required it. Since our last inspection a new

cook had been recruited. This allowed staff more time to provide support to people as they weren't required to assist with food preparation in addition to their care duties. Whilst staff and people living at the home felt there were enough staff to meet people's needs, we were concerned that a review of night staffing levels had not taken place as recommended by a fire risk assessor.

Staff were aware how to identify and report any safeguarding concerns they might have. We found the service had made referrals to the local authority safeguarding team and other agencies as required in relation to any instances of alleged abuse or neglect.

People told us they found staff competent and knowledgeable. Staff said they received sufficient training to enable them to meet people's needs. Training records showed staff had received training in a range of relevant topics, which would help them provide effective care to people living at the home.

We received positive feedback from people about the food provided. People had a choice of meal and could request and alternative if they wished. We saw staff monitored people's weights if required and people told us they were confident staff would contact their GP or other health professionals if they were unwell.

Despite feedback at our last inspection, the service had continued to use 'blanket' capacity assessments that were not decision specific. This increased the risk that people who were able to make certain decisions in relation to their care might not be given opportunity to make these choices. One person was being given medicines without their knowledge. Although we were assured this decision was made in consultation with others in this person's best interests, there was no formal record of this.

We received positive feedback from people living at the home and visitors about staff who we were told were friendly, caring and approachable. During the inspection we observed positive examples of staff communicating clearly and respectfully with people.

The home used CCTV and the network of cameras was being increased at the time of our inspection. The registered manager told us this was in response to recent safeguarding concerns to enable staff to be monitored. Cameras covered all communal areas including corridors and lounges. People living at the home and visitors we spoke with were unaware of the CCTV system. However, they all told us they felt it was a good idea to help keep people safe.

A new format of care plans were in the process of being introduced at the home. We found people's care plans contained variable levels of detail about people's preferences and how staff should meet people's needs. Some care plans lacked details about how staff should provide people with support, which increased the likelihood that appropriate care that met people's needs and preferences would not be provided.

Three people had moved into the home on an emergency basis two days prior to the second day of our inspection. We found no care planning or assessment of needs had been undertaken by the home. Staff had not completed any risk assessments and no records had been put in place in relation to these people's medicines. Staff were not aware whether one person had been administered a 'when required' medicine and the lack of any record meant there was a risk of them being given this medicine too frequently.

We received mixed feedback from people as to whether there were enough activities provided at the home. During the inspection we observed an external company supported an activity that engaged a number of people. Staff set up activities for other people such as colouring.

Some improvements had been made to the environment since our last inspection to make it more

dementia friendly. This included making people's bedroom doors different colours and changing the colour of the bathroom doors. A secure garden area was also being developed that people would be able to access. This would help people orientate around the home and allow them to access outdoor spaces safely.

Staff and visitors told us the registered manager was approachable and listened to them. During the inspection we saw staff regularly entered the office and discussed any issues or requested advice from the registered manager, which was provided.

There had been limited improvements to the quality assurance and audit processes in place to monitor and improve the quality and safety of the service. We found checks carried out were still not effective at identifying issues or driving improvements. The registered manager relied on the electronic medicines management system to identify any medicines errors or other issues in relation to the safe management of medicines. However, there was no evidence that where the system had identified errors that any action had been taken to investigate or rectify these issues.

We found evidence that the registered manager had not submitted all required notifications of serious injuries to the CQC as is a legal requirement. We had identified a similar issue at our inspection of the service in June 2015. This showed a failure to act effectively on feedback to make improvements to systems and processes.

The overall rating for this service is 'Inadequate' and the service therefore 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. 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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

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.

Staff were not following guidance from a healthcare professional in relation to one person's eating and drinking support needs. This placed the person at risk of choking.

The service were not able to demonstrate they had acted on the advice of a fire risk assessor to review night staffing levels and how they would carry out evacuations with reduce staff numbers.

Medicines were not managed safely and we found evidence people had not always received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

We received positive feedback about the food on offer. People told us they ate well and enjoyed their meals.

Despite feedback provided at our last inspection, the service had continued to use 'blanket' capacity assessments. This increased the risk people would not be fully involved in decisions about their care when they were able to contribute.

Staff told us they received sufficient training and support to enable them to provide effective care to people. Training records showed staff completed training in a range of relevant topics.

Is the service caring?

Requires Improvement

The service was not consistently caring.

We saw staff had left confidential care records out in communal areas of the home.

People told us staff treated them with dignity and respect. We observed staff were patient and polite when providing support to people.

Staff supported people to retain as much independence as was possible.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Three people had been recently admitted to the home on emergency placements. Two days after their admission there had been no care planning or assessment of needs carried out by staff.

We received mixed feedback about whether sufficient activities were provided. During the inspection we observed people engaged in and enjoying an activity run by an external company.

New care plans were being put in place. Care plans contained a variable level of detail about people's needs and preferences.

Is the service well-led?

Inadequate

The service was not well led.

Quality assurance and audit processes had not been effectively operated to identify and address issues in relation to the safety and quality of the service. We identified continued breaches of regulations.

The registered manager had not submitted notifications about all incidents as is a legal requirement.

Staff and visitors told us the registered manager was approachable and supportive.

Viewpark Care Home Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection took place on 8 and 9 August 2017 and was unannounced. The inspection team consisted of one adult social care inspector, an expert by experience and a specialist advisor who was a pharmacist. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service. This included any notifications the service had sent us about safeguarding incidents, serious injuries and other significant events that had occurred. Since our last inspection in November 2016 we had received a number of complaints and concerns about the service sent to us by email or using the 'Share your experience' forms on the Care Quality Commission website. We used this feedback to help plan our inspection.

A provider information return (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. On this occasion we had not asked the service to complete a PIR. This was because they had completed a PIR within the last year prior to their last inspection. We took this into account when inspecting the service and making judgements in this report.

We requested feedback about the service from the local authority quality and contracts team, Healthwatch Manchester and the community infection control team. We did not receive any feedback from the quality and contracts team, although they had contacted us in May 2017 when they told us they had found improvements at the service. The infection control team shared a recent infection control audit with us and

Healthwatch Manchester told us they had received no feedback about Viewpark Care Home. This information was also used to help plan the inspection and considered when making judgements about the service.

During the inspection we spoke with eight people who were living at Viewpark Care Home and three relatives who were visiting at the time of 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 five care staff (including two night staff), the registered manager, the deputy manager and the cook. We reviewed records relating to the care people were receiving, which included, seven people's care files, medicine administration records and daily records of care. We also looked at records related to the running of a care home. These included three staff personnel files, records of training and staff supervision, accident reports and records of servicing and maintenance of the premises and equipment.

Inadequate

Is the service safe?

Our findings

At our last inspection in November 2016 we found the administration of medicines was not always accurately recorded and there was evidence that people had not always received their medicines as prescribed. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. The provider had not made sufficient improvements, and we found a continued breach of this regulation.

Prior to this inspection we received concerns that staff were following unsafe practices in the administration of medicines. It was alleged that staff responsible for administering medicines were passing medicines to other staff members to give to people. This is unsafe practice and would mean the person responsible for medicines would not have observed the person taking their medicines. This increases the risk of medicines errors occurring. Whilst we found no evidence of this occurring during the inspection, we observed other poor practices in the administration of medicines. For example, we observed the member of staff responsible for administering medicines left medicines unattended on top of the medicines trolley for a short period of time. At one point they also dispensed medicines onto the top of the trolley and held them in their hand for several minutes whilst they found a medicines pot. This was unhygienic, and leaving medicines unattended increased the risk that people living at the home would unintentionally take medicines not intended for them.

We found that medicines requiring refrigeration were kept in appropriate storage. However, records of fridge temperatures showed the medicines fridge had been too warm (between 11 and 13 degrees celsius) over a four day period. We saw one person had medicines stored in the fridge and we were told they did not currently require their medicines as they were in hospital. The registered manager assured us they would dispose of the stock in the fridge and order a replacement supply. It is important that medicines are stored at the manufacturer's recommended temperature to ensure they do not spoil and work effectively.

Since our last inspection in November 2016, the home had introduced an electronic medicines management system. The administration of people's medicines was recorded on electronic medication administration records (MARs) by staff scanning barcodes on people's medicines containers before administering them. Although this system had built in features intended to prevent medicines errors occurring, we continued to find evidence of people not having received their medicines as prescribed. We found two people had not received their prescribed medicines due to stock having run out. One of these medicines was prescribed to help prevent the person experiencing muscle spasms. The person had gone without their medicine for a period of five days due to stock having run out. The registered manager told us this had been due to a change in the prescribed dose of the medicine and a delay in the GP signing the prescription. However, there were no clear records or audit trail at the home to evidence that there had been a change in the dose or when this had occurred. When there had been stock of this person's medicine, we also found the correct dose had not been consistently administered. The medicines records showed staff had administer a lower than prescribed dose on 10 occasions, and the remaining stock did not reconcile with either the recorded number of tablets administered, nor the number that should have been administered. This meant the person was at risk of experiencing pain and muscle spasms, and their

wellbeing was put at risk. We requested the registered manager to raise a safeguarding alert in relation to this concern.

We found stocks of medicines for three people who had been admitted to the home as 'emergency admissions' two days earlier. One of these people was shown in the social worker's assessment as being able to self-administer their medicines, whilst a second person's assessment recorded that they required support to manage their medicines. Staff told us they supported this person to take their medicines, but no records of administration had been completed. The lack of any medication administration records meant we could not tell whether they had received there medicines as prescribed. This was also unsafe practice as staff were also not able to tell whether people had already been administered their medicines, which put them at risk of receiving more or less than the prescribed dose. We raised this concern with the member of staff administering the medicines and they added this person to the electronic records system.

The issues outlined above showed that medicines were not being managed safely. This was an ongoing breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2016, we found the registered manager had not reported all potential safeguarding issues to the local authority and CQC as required. This included an instance where a vulnerable person had left the home unobserved. We found this to be a breach of regulation 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements had been made, and the registered manager had notified CQC and the local authority safeguarding team of any safeguarding concerns. The provider was now meeting the requirements of this regulation.

People told us they felt safe and well looked after. One person told us, "The home is safe enough for me and for everyone I think. Even though there are some residents who can be confused and wander about, staff make sure they are safe." Since our last inspection, we had received 10 notifications of safeguarding incidents from the service. This included a second incident where a person using the service had left the premises unobserved. The registered manager explained this had been due to a lock on a gate in the garden area having been damaged by unknown persons shortly after it had been checked and found to be working. The person returned to the home unharmed, and the registered manager had taken appropriate actions including reporting the issue to the local authority safeguarding team and CQC. Another incident reported to us involved a serious concern relating to an alleged sexual assault by a former resident. The registered manager had taken appropriate actions to safeguard people living at the home including liaising with the police and the local authority safeguarding team, and putting in place one to one support. The registered manager told us the police and the safeguarding team were satisfied with the actions the home had taken and had not considered it necessary to take further actions in relation to this incident.

Staff were not routinely recording what possessions people had or moved into the home with. We asked staff whether they had made any record of people's belongings for three people who had recently moved into the home. Staff confirmed no such record had been made, although they commented that they had considered introducing these records due to previous 'issues'. A record of people's belongings can help protect people from risks of potential financial abuse.

Records showed the registered manager had investigated safeguarding concerns when requested to do so by the local authority, and measures put in place to help prevent further harm occurring to people. In one case, concerns around the practice of night staff had been raised, and the registered manager had arranged for additional CCTV to monitor communal areas and deter further similar incidents.

Staff we spoke with were aware of how to identify and report potential safeguarding concerns, and told us

contact numbers for the local authority safeguarding team were displayed in the office if they required them. We found one person living at the home had a protection plan in place, which identified steps staff should take to help ensure they, and others living at the home were kept safe. Staff we spoke with were aware of the details of this plan and what they were required to do to help prevent any harm occurring.

At our last inspection in November 2016 we identified concerns in relation to safe staffing levels. During that inspection, staff on duty had been required to work in the kitchen due to the absence of the regular cook. We had also identified ongoing concerns around whether two staff during the night shift were sufficient to meet people's needs. We found this to be a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found some improvements had been made and the provider was meeting the requirements of this regulation. However, at this inspection we continued to have concerns in relation to how the service determined required staffing levels during the night period, which we found to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as detailed later in this section of the report.

The registered manager told us staffing levels for care staff had not changed since our last inspection other than the addition of a 7am to 11am shift to provide additional support in the mornings. The registered manager had recruited a new cook, which also provided staff with more time to support people during meal times. We observed that staff responded to call bells promptly, and no-one we spoke with raised any concerns about having to wait to receive support. One person told us, "Day or night I always see staff. They are lovely." A second person told us, "Staff never make you wait." We saw communal areas were sometimes left without supervision for short periods of time, although staff frequently passed and looked in on these areas.

Staff we spoke with, including night staff, told us they felt there were sufficient numbers of staff on duty to meet people's needs in a timely way. However, some staff told us in the past there had been a higher level of staff on duty and that this had allowed staff more time to spend one to one and interacting with people living at the home. Staff told us shifts were always covered if a staff member was off work or attending training. We reviewed staff rotas, which confirmed this. The night staff and registered manager told us staffing levels at night were increased from two to three staff if there was someone who required additional support due to their current care needs. Staff were able to give us recent examples of when this had been done. This showed people's needs were considered when the registered manager decided how many staff were required on each shift.

We saw evidence that required checks and maintenance had been carried out in relation to the premises and equipment used. For example, we saw records of a gas safety check, electrical fixed wiring test and a check and service of lifting equipment such as hoists. Prior to the inspection we received a copy of a recent infection control audit carried out by a health protection nurse in May 2017. This indicated actions had not been taken to address concerns raised in the provider's legionella risk assessment. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease that can be dangerous, particularly to more vulnerable people such as older adults. The registered manager was able to show us evidence that the required actions had been completed and that actions to help prevent legionella were now being undertaken as required.

Whilst some measures had been taken to help ensure people's safety in the event of an emergency such as a fire, we found the provider had not taken all reasonably practicable measures to act on known risks. People had personal emergency evacuation plans (PEEPS) in place. These provided details about the level of support people would need to evacuate in an emergency that would be of use to staff and the emergency services. Records showed fire safety systems including the fire alarm and fire extinguishers had been

regularly checked and serviced. Staff had received fire safety training and had undertaken fire drills.

However, we found the provider had not acted upon all recommendations made in a fire risk assessment completed by a third party fire risk assessor in May 2016. The risk assessor had suggested three staff may be required at night to carry out an effective evacuation and recommended that the home consider staffing levels at night in conjunction with a review of the evacuation plan. They also recommended that the evacuation procedures were tested to ensure their suitability. The registered manager was not able to provide any evidence that staffing levels at night had been considered in relation to evacuation of the premises. At the time of the inspection they were also unable to provide a copy of the home's evacuation plan. The registered manager told us they had an agreement with neighbours and a nearby care home who would assist with any emergency evacuations. Shortly after the inspection the registered manager sent us an updated evacuation plan and risk assessment that considered arrangements for evacuation during periods of reduced staffing, such as during the night.

The provider had failed to take reasonably practicable actions to assess and reduce risks to people using the service in the event of fire. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2016, we found risk assessments in relation to malnutrition had not been regularly reviewed. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found an ongoing breach of the regulations in relation to the assessment and mitigation of risks to people's health and welfare.

We looked at the care records for three people who had moved into the home two days previously. Staff also told us they had not had opportunity to record the weights of these recently admitted people, despite one of these people having documented concerns about their food and fluid intake in the social worker's assessment. None of the three people had had any risk assessments completed in relation to their care, including any assessment of risks relating to falls, malnutrition or pressure ulcers. This showed the service had not assessed potential risks to these people's health and wellbeing to allow them to provide care and support that would reduce risks of harm occurring.

In other care files we found risk assessments had been completed in relation to a range of potential hazards to people's health and wellbeing. This included risks relating to falls, malnutrition, pressure sores and diabetes. Risk assessments relating to pressure sores and malnutrition had been reviewed monthly, which was an improvement since the last inspection. This would help the registered manager identify if anyone's needs had changed or their risk increased requiring additional measures to be taken to help keep them safe. However, we found other risk assessments had not been regularly reviewed and were not always up to date. For example, one person's diabetes risk assessment stated they took a medicine called metformin to help control their diabetes. However, we saw in other care records in this person's file that this medicine had been discontinued. We also found some risk assessments lacked details that would be important for staff to know. For example, moving and handling risk assessments did not detail which loops to use on people's slings if they required hoisting.

In other instances we found staff were not following care plans and risk assessments to help keep people safe. We saw one person looked very 'slumped' in their wheelchair whilst eating their meal. They were not being supervised by staff and did not have a lap belt on. We were concerned this person may be at risk of slipping out of their wheelchair. Staff told us a lap belt was not required and that this person was not at risk from falling from their chair. However, when we reviewed this person's wheelchair risk assessment, it stated a lap belt should be used and that staff should supervise this person whilst in their wheelchair to keep them

safe. Following our inspection, the registered manager sent us a revised risk assessment that indicated this person's wheelchair lap-belt should be used only when they were being pushed in their wheelchair.

We saw this person had also been seen by a speech and language therapist (SaLT) in relation to swallowing difficulties they had that presented a potential risk of choking. The most recent SaLT assessment advised that this person was provided with a pureed diet and custard consistency drinks. Their care plan and SaLT assessments also indicated they would require staff supervision and support whilst eating and drinking. However, we saw this person was left unsupervised when eating and drinking on more than one occasion. We also saw this person was given biscuits to eat, which was contrary to the advice from the SaLT and put them at risk of choking. Records of their food intake also showed they had been given inappropriate texture foods, including toast on several previous occasions. We saw this person had been given a drink that was of a syrup consistency rather than the advised custard consistency and queried what guidance staff were following when preparing this person's drinks. The kitchen staff showed us they were following the directions on the prescribing label on the person's thickener. Staff had not questioned or acted upon the reason for the conflicting information between the prescribing label and the advice from the SaLT, which we later found was due to an acknowledged error by the GP in not changing this person's prescription following letters from the SaLT. This person had been placed at unnecessary risk of aspiration due to staff not following the recommendations of a healthcare professional. Due to our concerns we raised a safeguarding alert with the local authority, and the registered manager told us they would seek an urgent re-assessment from the SaLT team.

The above examples show the provider was not effectively assessing or acting to reduce risks to people's health and wellbeing. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at records of staff recruitment. We saw staff had completed an application form and provided a full employment history. The provider had carried out other required checks to help ensure the staff they recruited were of suitable character to work with people living at the home. This included seeking references from previous employers, obtaining proof of identity and a disclosure and barring service (DBS) check. A DBS check provides details of any convictions the applicant has and whether they are barred from working with vulnerable people. This helps providers make safer decisions in relation to staff recruitment.

In one instance the records showed a staff member had started work prior to their DBS check having been returned. There was also a note in this staff member's file that stated they would only shadow staff until their full DBS check had been returned. The registered manager told us an 'adult first' check had been obtained for this staff member prior to them starting work. Staff are able to commence work with an adult first check, prior to a full DBS check being returned in certain exceptional circumstances and when appropriate additional safeguards are put in place. However, the manager was not able to provide evidence that the adult first check had been obtained so we could not be certain that the correct and safe procedure had been followed in this case. All other records we looked at indicated full DBS checks had been received prior to the staff member commencing work.

Requires Improvement

Is the service effective?

Our findings

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

At our last inspection in November 2016, we found DoLS applications had not always been made when people were subject to restrictive practices. We found this to be a breach of Regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made, and the provider was meeting the requirements of this regulation.

We found the registered manager had identified people who were subject to restrictive practices and had submitted DoLS applications to the supervisory body as required. This included a DoLS application that had been submitted for the person who had left the home without supervision as discussed in the safe section of this report. Staff we spoke with were aware of the people who had an authorised DoLS and were able to tell us the reasons that someone might require a DoLS.

At our last inspection we found that 'blanket' capacity assessments that were not decision specific were contained in people's care records. We found this was still the case, and this would increase the risk that staff and others involved in a person's care would assume the person was unable to make any decisions in relation to their care and day to day life when this may not have been the case. We found some people's care files contained forms they could sign to consent to their care plans. However, these were not always signed and if the person did not have capacity to consent, it was not documented whether a best interests decision had been undertaken. However, staff had a good understanding of the MCA and were able to explain how they would work within the principles of the MCA. For example, staff told us they would support people to make their own decisions whenever possible, and told us if people lacked capacity they would act in their best interests. During the inspection we saw staff routinely asked people for their consent and gave people choices such as where they sat during and after meal times.

The registered manager told us one person was administered medicines covertly (without their knowledge). A judgement by the Court of Protection in July 2016 clarified the steps required in relation to the administration of covert medicines. This judgement indicated that covert medicines be considered in exceptional circumstances, but that a best interests meeting should be held prior to providing medicines covertly. A record of the decision making should be contained in the person's care records and should be

easily accessible. The registered manager told us this person's family had wanted their family member's medicines to be administered covertly, and there was reference within this person's DoLS application to a discussion with their GP and the social worker regarding the administration of medicines covertly. However, there was no clearly recorded decision in relation to the administration of covert medicines, and whether this was in the person's best interests. The registered manager told us there had been a best interests meeting arranged in relation to other aspects of this person's care and that they would highlight this issue for discussion.

We recommend the provider reviews their processes for recording and reviewing best interest decisions and capacity assessments in accordance with the MCA code of practice and other relevant guidance.

People we spoke with told us they found staff to be competent in providing any care and support they needed. One person said, "Whenever I need staff for anything, I don't struggle, they do their job very well." Another person told us, "Staff seem to have all the answers."

Staff told us they received sufficient training to allow them to meet people's needs effectively. They told us they could also request additional training in any areas of need they identified or had a particular interest in. Staff told us, and training records confirmed that staff had completed training in a range of topics relevant to providing support to people living at the home. This included safeguarding, moving and handling, first aid, dementia, nutrition, health and safety and MCA and DoLS. We spoke with one staff member who had recently started work at the home who told us they were in the process of completing the care certificate. The care certificate is a set of minimum standards that should be covered as part of the induction of any staff new to care. They told us they had been given the opportunity to shadow experienced staff during their induction and had felt confident to work without support at the end of their induction period.

Staff told us they received regular supervision where they had the opportunity to receive feedback about their performance as well as to discuss any concerns. The registered manager told us staff would receive supervision four times per year. We looked at an overview of supervisions, which showed most staff had received between one and two supervisions since the start of 2017. Records of supervisions showed topics of discussion in supervisions included training and feedback on observations of staff practice. This meant staff received appropriate support to help ensure they carried out their roles effectively.

We received positive feedback from people about the food provided at the home. Comments included, "There is some lovely food on the menu; we are very well fed", "Most of what they give you is very nice. They write it down on the board so you can see what's being offered" and "We get given enough good food and staff ask if you're ready for dinner." We saw people's care plans referred staff to a 'preference sheet' in relation to people's food preferences. We asked the registered manager about the preference sheets and were told they were no longer in use. We asked the cook how they developed the menu to meet people's preferences. They told us, "When I started working here I went to ask the residents and staff what everybody likes and if they wanted any changes to be made. I discovered they don't like anything new, they simply love old English tradition dishes."

Other than the instance referred to in the safe section of this report where staff were not following a person's eating and drinking guidance, we saw people received the support and encouragement they needed during meal times. People were offered a choice of meal, and were offered alternatives if they did not like what was on the menu. Staff checked that people had had as much to eat as they wanted, and people were given the choice to eat where they wanted. For example, we saw one person left the table and staff went after them and said, "Do you want me to bring over your food in the sitting room, or do you fancy dessert or something else later?"

We saw people's weights were regularly monitored when required, and there were regular reviews of risk assessments relating to people's risk of malnutrition. This would help ensure staff were able to identify and act upon any potential health concerns. Records showed that staff contacted other health professionals as required where there were concerns about a person's health. One relative we spoke with said, "My [relative] was losing weight. Staff made some referrals and they are now picking up some weight. They have been to see their GP a month ago." A person living at the home told us, "If I am not well, staff take me to see my GP."

At our last inspection in November 2016, we made a recommendation that staff review good practice guidance in relation to developing dementia friendly environments. We saw there were a number of adaptations to make the environment more dementia friendly, which included pictorial signs on rooms around the home. The registered manager told us that since the last inspection they had also changed the colour of bedroom and bathroom doors, which would help people identify their room and the bathrooms. We saw a secure outdoor garden area was also in the process of being developed, which would increase opportunities for people to access an outside space.

There were two main lounges, a conservatory, a quiet lounge and a two adjoining dining rooms at the home. This meant there was plenty of room for people to move around the home and to access quieter areas if they wished. However, we found the dining areas were cramped during meal times, and due to the limited space this meant people also had to leave their mobility aids outside in the corridor. This could limit people's independence and would also potentially increase risks in relation to falls.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found care was not always carried out with respect, and people's independence was not always supported. We found this to be a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting the requirements of this regulation, although further improvements were required.

We received positive feedback from people living at Viewpark Care Home and their relatives about the kind and caring approach of staff. Comments included, "Staff are very friendly and I don't think anyone will do me harm. I made some friends", "The staff are very nice; we have a good laugh and they help with anything you need" and "The attitude of staff is very pleasant. They drop everything to care for residents, and if you want answers they are very helpful." All staff we spoke with told us they would be happy for one of their friends or relatives to receive care at the home should they require such care.

During the inspection we saw staff interacted patiently and respectfully with people living at the home. We saw staff greeted people using their names and observed staff introducing people who had recently moved in to staff who had not yet met them. We spoke with two of the people who had recently come to stay at Viewpark Care Home. They told us, "I have only been here a short while and staff treat me with such compassion." We observed staff supporting someone using a hoist and they worked at a pace comfortable to the person they were supporting, and gave clear explanations of what they were doing. This would help reassure this person whilst this support was provided.

At another point in the inspection we found evidence of less good practice. We observed a staff member supporting a person to eat a pureed meal. We asked the staff member what the meal was and they could not tell us. This information would have been useful to assist the person in making a choice about their meal. The staff member was also assisting this person whilst sat on the arm of their chair. There was very limited communication from the staff member and the TV was on loudly in the room where this person was eating. This meant the person was not being supported in a person centred way, and the environment was not conducive to effective support being provided. The registered manager came into this room whilst the staff member was assisting and directed them to get a chair and to get eye contact with the person they were supporting. This showed the registered manager maintained an awareness of, and challenged staff poor practice.

Despite positive feedback about the caring approach of staff, we found that failings in relation to the safety and responsiveness of the service meant staff were limited in being able to provide a caring service. For example, staff were not consistently following risk assessments and care plans such as managing risk of choking, which placed people at risk of harm. Care planning and assessment for people who had recently moved to the home was also limited. This meant there was a greater likelihood that staff would not provide care and support that met those people's needs and preferences.

At our last inspection in November 2016, we had found improvements had been made in relation to maintaining the confidentiality of people's records. However, at this inspection we again found confidential

care records had been left out in communal areas. On the first and second days of our inspection we saw a daily record of care and continence recording chart for a person had been left out on a desk in the main lounge. The registered manager told us this had been due to the staff updating these records, although they were not present in the lounge at the time we saw them. This meant care records were not always being kept securely and confidentially.

People told us staff respected their privacy. One person told us, "They are good staff and they always allow me to keep my space." We asked staff how they would respect people's privacy and they told us they would knock on people's doors before entering and involve people in decisions about their care.

The home had extensive CCTV coverage of the majority of communal areas within the home including the lounges, dining areas and corridors. We saw the home had a policy that detailed the purpose of the CCTV and demonstrated that the provider had given consideration to handling recordings in accordance with legal requirements. The registered manager told us staff, relatives and people living at the home had all been made aware of the presence of the CCTV system. They showed us a letter that had been sent out to tell people about the CCTV being installed and asking them to raise any concerns they might have about the system. Although everyone we spoke with felt the use of CCTV was a positive way of helping ensure people's safety, none of the visitors or people living at Viewpark Care Home we spoke with had been previously aware of the recordings being made. One relative said, "I am a bit annoyed we didn't know about it, but at the same time I am happy that the home has decided to reassure people's safety in the home." A person living at the home told us, "I think it's [the CCTV] a good thing for everyone."

People told us staff supported them to retain as much independence in the home as possible. One person said, "Staff do most things for me, but they do still encourage me to choose my clothes and some things that I can do myself." A second person said, "I do lots of things for myself. The staff support me here and there." During the inspection we saw one person was helping staff to set tables in preparation for the meal. This allowed the person to be involved in the running of the home and retain independence and skills. Staff told us they would support people to do what they could for themselves before they did something for someone. We heard staff discussing the care of a person who had recently moved to the home and this included discussions around the importance of allowing this person to maintain as much of the independence they were used to.

The registered manager told us they intended for the home to complete the gold standards framework for end of life care. At the time of our inspection the registered manager and deputy manager had completed this training. The gold standards framework is an evidence-based approach to providing effective end of life care to people. We saw people's end of life care wishes had been considered and recorded in their care plans.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2016, we found care plans did not always provide sufficient detail about how staff should meet people's needs. One person who had recently moved to the home had very limited details recorded about the care they required. We found this to be a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had not been made, and there was an ongoing breach of this regulation.

Since our last inspection the home had started to introduce a new format of care plan. These had been completed for some people, and were partially complete or had not been started for others. Care plans contained variable levels of detail about people's preferences, social histories, likes and dislikes. They also varied in relation to the level of detail that was given about how staff should meet people's needs. In some care plans there was detailed information, whilst in others information was limited. For example, one person's care plan for personal care stated that staff should 'assist with personal care' but did not provide detail on how staff should do this. A second person's care plan stated '[Person] needs assistance with eating and drinking] but provided no further information on what assistance they required. Care plans had been recently reviewed, although we found that the reviews sometimes contained more information than the actual care plan. For example, one person's continence care plan was blank, although the care plan review contained details on how this person's continence support needs were met.

The registered manager told us three people living at the home had been emergency admissions the day prior to our first day of the inspection. On the second day of our inspection we asked to see the care planning and assessment of these people's support needs that had been carried out by the home. We found there had been no recorded assessment of these people's care needs or preferences by staff at the home either prior to or following their admission other than completion of daily records of care.

The registered manager told us they had received an assessment from a social worker and also had discussions by phone to help decide whether they were able to accept these emergency admissions. We asked if there was any formal agreement with the crisis team making the admissions as to the expected level of information the home would be provided with to ensure they were able to provide safe and effective care to people once they had moved in. The registered manager told us there was no formalised agreement.

We reviewed the social worker assessments for the three people who had moved in. Whilst the assessments did not indicate any significant or complex care needs in relation to the three recent admissions, it was concerning that the home had not undertaken any assessments in relation to these people's care needs or preferences by the second day after their admission. For example, there were no assessments relating to mobility, continence, nutrition or social support needs. There was also no information of any preferences these people had in relation to their care and support.

This was an ongoing breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were able to make day to day choices in relation to their care and routines at the home. For example, people told us they were able to decide what time they got up in the morning. One person said, "We are not bound by rules. If you fancy lying in bed, you do it." We saw one person asked staff to receive support to shower that day and staff agreed to do this.

At our last inspection in November 2016 we found there were not sufficient activities provided to meet people's needs. We found this to be a breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was now meeting the requirements of this regulation, although there was scope for further improvements in this area.

We received mixed feedback from people in relation to whether there were sufficient activities provided at the home. One person told us, "People come and do exercises and dance with us. Before I came here I used to go dancing." Another person said, "It is a bit quiet at times, but I feel alright about it. I do my colouring every day and go to the market every week with staff. I like shopping."

On the first day of our inspection we saw an external company had come to the home to do a seated exercise and games session. People were engaged in the activity and we saw people smiling and laughing during the session. After the session one person told us, "It was fun. I mean everyone deserves to have some fun every once in a while" and a second person said, "You forget you are old. I only wish it [the activity] could happen too often." On the second day of our inspection we saw less in the way of activities taking place, although we observed staff spending time talking with people and setting up activities such as colouring. Activities are an important part of meeting people's social care support needs and can help support people's physical and psychological wellbeing.

We found staff at the home supported people to maintain relationships with people that were important to them. For example, one person's care plan stated that the person had a close friendship with two other people living at the home and that they liked to eat meals with, and sit in the lounge with their friends. Staff were aware who this person's friends were and we saw they were sat together in the lounge. People told us their relatives and friends were able to visit without restrictions. One person told us, "Staff are very approachable. They let my family come and see me anytime and let my daughter bring her dog to see me."

People living at Viewpark Care Home and visitors we spoke with told us they would feel comfortable raising a complaint if they felt this was required. One person said, "If I am not happy I will tell staff," and a visitor told us, "I've never needed to complain. If I have any concerns I will talk to management." Most people told us they had not needed to raise any complaints, although one visitor we spoke with told us the registered manager had acted upon their concern to their satisfaction. They told us, "I have had my [family member's] clothes being mixed up with other residents and have said something to the manager. She was very nice and very apologetic and she made some changes, and now I'm happy." We saw a record of complaints that showed the registered manager had investigated complaints and provided responses as required.

Inadequate

Is the service well-led?

Our findings

The home had a registered manager who had been in post for over five years. A deputy manager supported the registered manager with aspects of the day to day running of the home. Prior to the inspection we received multiple concerns about the registered manager's approach and treatment of staff. This was also raised as an issue by staff during our last inspection. We shared these concerns with the local authority quality and contracts team who following enquiries told us they felt this was a staffing issue.

During this inspection no concerns were raised with us in relation to the registered manager's support of staff or approach to the management of the home. Staff and visitors told us the registered manager was approachable and listened to them. One person living at the home told us, "The manager is a lovely girl, very caring," and a visitor said, "I have known [registered manager] for a long time. She is very nice and approachable." During the inspection, we observed that staff frequently entered the office and were comfortable requesting support or discussing issues with the registered manager. Staff told us the registered manager or a senior carer was always contactable should they need any advice.

The registered manager told us they felt the home and staff had worked hard to make improvements since our last inspection. We saw the provider had also commented at a staff meeting that they wanted to 'see good [rating] for all the hard work of staff'. Staff told us they felt improvements had been made, such as the introduction of the electronic medicines management system, although this is an area where we also identified concerns. The registered manager told us they felt the last inspection report had not been a fair reflection of the service, which they felt was due to issues they felt had previously existed within the staff team. However, they also told us they believed improvements had been made since the last inspection.

At our last inspection in November 2016, we found systems for auditing care files and medicines were not effective. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had not been made and there was an ongoing breach of this regulation.

The registered manager showed us surveys that had been received from people living at the home and their visitors. The feedback from these was generally positive, although there was no recorded analysis of the information, which would have helped the registered manager identify areas where improvements could be made.

We asked the registered manager whether they carried out spot-checks on staff during the night. The registered manager told us they did do spot-checks and also used the CCTV system to check staff were completing their duties as intended during the night. However, the last recorded spot check took place in April 2017, and there was no further record of checks being carried out either in person or remotely via the CCTV system after this date. This meant we were not able to see if any issues had been identified by these checks, or whether they were used to help drive improvements in the quality and safety of the service.

Since the introduction of the new electronic medicines management system the registered manager had

relied upon audits and checks built into the system. The registered manager showed us that they were able to run reports in relation to medicines that had been administered that highlighted instances where people's medicines had run out of stock or not been administered for instance. However, there was no record or evidence that any action had been taken in response to such incidents. We found issues in relation to the safe management of medicines, including instances when people had not received their medicines as prescribed and where there were no records of medicines administered. This demonstrated that reliance upon this system was not robust enough to ensure people's medicines were managed safely.

The registered manager completed a regular walk-round, which they called a dignity audit. This was used to note the registered manager's observations in relation to different aspects of care provision. However, there were no clear actions identified as a result of these audits to help identify areas for improvement. We noted in our previous two inspections in November 2016 and June 2015, that the audit of care plans was not sufficiently robust as there was no clear record of what aspects of the care plans had been checked. At this inspection we found the audit had still not been developed despite this previous feedback.

We saw a record of accidents and incidents was maintained, and a simple audit was carried out that indicated a running tally of the number of falls/accidents a person had sustained. However, we found this audit check had not been completed for July 2017, and not all accident reports had been transferred to this file, which would limit how effective this audit was. The audit tool had check boxes against the log of incidents to indicate whether a person's care plans and risk assessments had been reviewed following any accidents. In many cases we saw the box was ticked to indicate this had not been done, however no explanation was provided as to why such actions had not been considered necessary.

The audit and quality assurance systems had also failed to ensure sufficient improvements in relation to areas of concern identified during this, and previous inspections. This included concerns in relation to the assessment and management of risk, and ongoing concerns in relation to the safe management of medicines and effective assessment and care planning.

Systems in place to assess, monitor and improve the safety and quality of the service were not effective. This was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in November 2016 we found complete and contemporaneous records of care were not always maintained. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found an ongoing breach of this regulation.

We found staff kept complete and up to date records of care as required. However, we found other records required in relation to the management of the service were not always accurate or available. For example, we found people's medicines records did not always reflect what medicines staff had administered. We also found checks of the controlled drugs were not always clearly recorded on a separate line, which made it difficult to tell whether stock checks had been accurate. Controlled drugs are medicines that are subject to additional legal controls in relation to their storage, administration and destruction due to the risk of their misuse. We noted at our last inspection that the service was unable to provide any records of residents meetings, and this continued to be the case at this inspection as staff could not locate the meeting book.

The failure to maintain complete records in relation to the management of the service was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the provider regularly visited the home to check on progress. We also saw

evidence they had been involved in staff meetings. We looked at minutes of staff meetings, which showed discussions had included staffing levels, record keeping and policies and procedures. This would help ensure all staff were aware of their responsibilities and the correct procedures to follow at the home.

Services such as Viewpark Care Home are required to submit notifications to CQC about certain incidents and events that occur when providing a service. This includes any serious injuries that are sustained by people using the service. Whilst reviewing care records we found evidence that a person had fallen and sustained a fracture that resulted in a hospital admission in April 2017. Although we did not have any concerns with how this incident was handled, we found we had not been notified of the incident as required. It is important that CQC is notified of such events to enable us to monitor the safety and performance of services and take action when required. The registered manager told us they had not submitted the notification due to them being on leave at that time. We had raised similar concerns at our inspection in June 2015 when we found notifications of serious injuries and DoLS had not been submitted. This was a breach of Regulation 18(1) of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection in November 2016 we found the provider was not displaying the performance rating they received at their last CQC inspection in June 2015. This was a breach of Regulation 20A(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the home was displaying their most recent rating as required. The provider did not have a website on which to display any rating.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified CQC of a serious injury sustained by a person using the service. Regulation 18(1)

The enforcement action we took:

The provider paid a fixed penalty notice of £1250.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not carried out sufficient assessment of people's needs and preferences. Regulation 9(1)

The enforcement action we took:

We cancelled the provider and registered manager's registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being managed safely. The provider had failed to take reasonably practicable actions to assess and reduce risks to people using the service in the event of fire. The provider had not taken reasonable actions to identify and mitigate risks to people's health and wellbeing. Regulation 12(1)

The enforcement action we took:

We cancelled the provider and registered manager's registrations

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess, monitor and improve the safety and quality of the service were not effective. The provider had failed to maintain complete records in relation to the management of the service. Regulation 17(1)

The enforcement action we took:

We cancelled the provider and registered manager's registrations