Russley Care Homes Limited

Parkview Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 22 and 23 September 2016 and was unannounced. We last inspected the home on 24 July 2014. The provider was meeting the requirements of the regulations we inspected against.

Parkview Care Home is registered to provide nursing care to older people. The home can accommodate up to 24 people. At the time of our inspection 19 people were living at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had breached the regulations relating to person-centred care. Risk assessments had not been personalised to the needs of each person and some were out of date. Some care plans were not up to date and others lacked personalised information to ensure people received appropriate care.

Quality assurance systems were not effective in proactively identifying issues we found with care planning and risk assessments.

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

The provider had not always followed the requirements of the Mental Capacity Act (MCA) 2005. A decision to provide a specialist bed for one person lacking capacity had been made without a MCA assessment and best interest decision having been made first. We have made a recommendation about this.

Deprivation of Liberty Safeguards (DoLS) were not in place or applied for all people who were unable to consent to their placement in the home. The registered manager advised us this was following advice from the local authority responsible for processing DoLS applications.

Care workers supported people to make as many of their own choices and decisions as possible.

People and care workers felt there were enough care workers on duty to meet people's needs. Staffing levels were monitored and staffing levels had increased as a result of the most recent review of staffing levels.

People said they were happy with both their care and the care workers who provided it. They said care workers were kind and caring and treated them with respect.

Care workers demonstrated a good understanding of safeguarding adults and whistle blowing, including how to report concerns. All of the care workers we spoke with said they would have no hesitation raising concerns to keep people safe.

Medicines records we viewed supported the safe administration of medicines. Medicines administration records (MARs) were accurate and medicines were stored securely.

Regular health and safety checks were carried out to help keep the home safe, such as checks of fire safety, water and the gas supply. Information was available about people's care and support needs in an emergency situation.

Incidents and accident logs were kept which detailed investigations and action taken to help prevent accidents reoccurring.

Care workers told us they received good support. Records were available to show care workers had regular one to one supervisions and appraisals. Training records conformed essential training was up to date for care workers.

People were happy with the meals provided at the home. We observed during the lunch time there were not enough staff available in the dining room to provide support in a timely manner.

Care records showed people had regular input from external health professionals in line with their needs, such as GPs and community nurses.

People's needs had been assessed and care plans developed. Some care records provided care workers with information about people's preferences, such as their likes and dislikes.

Activities were available for people to participate in if they chose to, such as games, manicures and one to one time with care workers.

People knew how to complain but said they did not have any concerns about their care. Records showed previous complaints had been thoroughly investigated and resolved.

People said the registered manager was approachable and the home had a good atmosphere.

An individual daily record of the care people had received was not kept for people using the service.

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

The service was safe.

Medicines were managed appropriately.

Care workers understood safeguarding and the provider's whistle blowing procedure. They also knew how to report concerns.

There were enough care workers on duty. Recruitment checks had been carried out to ensure care workers were suitable to work at the home.

Health and safety checks were completed to help keep the home safe.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had not always followed the requirements of the Mental Capacity Act (MCA) 2005 including the Deprivation of Liberty Safeguards (DoLS).

Care workers supported people to meet their nutritional needs.

Care workers felt they received good support. Essential training was up to date.

People had regular input from external health care services.

Is the service caring?

Good

The service was caring.

People gave positive feedback about their care.

People said staff were kind and caring.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some care plans did not reflect people's current needs and preferences.

Activities were available for people to access if they wanted.

Complaints were dealt with in line with the provider's agreed procedure.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance systems had not been effective to ensure care plans and risk assessments were accurate.

Individual daily records were not kept for each person

People gave positive feedback about the management of the home.

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 inspection took place on 22 and 23 September 2016 and was unannounced.

The inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also viewed the recent inspection report from the local authority commissioners of the home.

The provider completed a provider information return (PIR) prior to the inspection. This 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 spoke with five of the 19 people who used the service. We also spoke with the director, registered manager, two senior care workers and two care workers on a one to one basis. We observed how care workers interacted with people and looked at a range of care records which included the care records for four people, medicines records for 19 people and recruitment records for five care workers.

Good

Is the service safe?

Our findings

People said they felt safe living at the home. One person told us, "They do look after you, there is no doubt." Care workers confirmed they felt people were safe. One care worker said, "Oh yes they are definitely safe. We are always aware of what is going on in the home. If we see anything it is reported to management. Things always get sorted." Another care worker told us, "I think they are safe. They have everything they need."

All care workers we spoke with demonstrated a good knowledge of safeguarding adults, including how to report any concerns they had. For example, they knew about various types of abuse and potential warning signs to look out for. Care workers told us they would report any concerns to the registered manager straightaway. Training records confirmed care workers had completed recent safeguarding training. The provider's safeguarding log confirmed that the four safeguarding concerns had been referred to the local authority safeguarding team as required and investigated fully.

Care workers knew about the provider's whistle blowing procedure. They told us they had not used the procedure whilst working at the home. Care workers also said they would have no hesitation if they were concerned about a person's safety. One care worker commented, "We are most definitely able to raise concerns. I wouldn't be frightened I would just say something." Another care worker told us, "I have not seen anything [of concern]." A third care worker said, "[Registered manager] is really good, they would deal with it [a concern] appropriately."

The provider carried out assessments to help keep people safe from a range of potential risk, such as poor nutrition, falling and skin damage. Where people were assessed as being at risk action had been taken to help keep them safe. For example, additional monitoring and nutritional supplements where people had lost a significant amount of weight.

Medicines records supported the safe management of medicines. Only trained care workers whose competency had been checked administered medicines to people. We viewed medicines administration records (MARs) and found they had been completed correctly to account for the medicines people were given. Where medicines hadn't been given codes were used to confirm the reason, such as a person refusing or medicines not required. Medicines were stored securely in locked medicine trolleys which were kept in the care workers work station. Checks were carried out to ensure medicines which needed to be kept chilled were stored at the correct temperature. Other medicines records, such as for the receipt and return of unused medicines were up to date. Regular medicines audits were carried out to check that people had received their medicines as required. One person said, "They give me all my different medicines."

People said there were enough care workers on duty to meet their needs. One person commented, "Yes, they really do come quickly [if I need help]." Another person commented, "I have a buzzer, it [response from staff] is not bad at all." Care workers also felt there were enough staff. One care worker told us, "Staffing levels are okay." Another care worker commented, "We have enough staff, we can see to people's needs quickly." Staffing levels were monitored periodically to monitor people's dependencies. The registered manager told us staffing levels had been increased following the most recent assessment in July 2016 due to

people's needs changing. Care workers told us additional staff had been provided to cover additional demands on staff, such as when providing end of life care.

The provider had completed effective recruitment checks to confirm new care workers were suitable to work with people using the service. These included various pre-employment checks, such as requesting and receiving references and checks with the Disclosure and Barring Service (DBS). DBS checks are carried out to confirm whether prospective new care workers had a criminal record or were barred from working with vulnerable people.

Incidents and accidents were logged and investigated. The details of any action taken to help keep people safe were clearly documented. This included seeking medical advice and additional monitoring to help keep people safe. Incidents and accidents were analysed and monitored each month to look for trends and patterns.

Regular health and safety checks were carried out to help keep the home a safe place for people to live in. For example, checks of the fire safety systems, water and gas safety. Records confirmed these were up to date when we visited the home. The five year electrical installation certificate was unavailable to view when we inspected the home. We have asked the provider to forward this to us separately. Servicing and checks were up to date for specialist equipment used in the home. This included checks of moving and assisting equipment to help people with mobilising. We found the home was clean and tidy when we visited. Some areas of the home required re-decoration and painting. The registered manager told us this had already been identified and a plan was in place.

The provider had procedures in place to deal with emergency situations. The provider's 'continuity and disaster recovery plan' had been recently updated. The plan identified the measures in place to deal with a range of emergency situations such as loss of staff and the premises. Information about each person's evacuation needs in an emergency were readily available to the emergency services.

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 application 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.

Due to circumstances outside of the provider's control DoLS authorisations had not yet been agreed for all people requiring authorisation. Nine applications had been submitted to the local authority with a further seven needing to be sent. From our discussions with the registered manager, it was clear they understood the process for submitting DoLS applications. However, due to a local delay in processing applications the local authority had not yet assessed some of these DoLS applications. The registered manager told us the other applications had not yet been submitted following advice from the local authority to send them in on a phased approach. A matrix was in place to keep track of the progress with DoLS applications.

We found a decision to trial a specialist bed, with bed sides, for one person without capacity had been made without following the requirements of the MCA. The registered manager told us they had made the decision, following discussions with the district nurse and family members and following a risk assessment having been carried out. Although the decision was taken to keep the person safe by preventing them from rolling out of bed and injuring them self, we found no evidence of a MCA assessment and best interest decision having been made.

We recommend the provider researches and follows current guidance in relation to the Mental Capacity Act and takes action to update their practice accordingly to ensure decisions for people lacking capacity are only taken following a documented MCA assessment and best interest decision.

Care workers described the strategies they used to support people with decision making. One care worker said, "We ask families about [the person's] previous life so we know their likes and dislikes." They went on to describe how, when supporting people to get dressed, they would show them clothes to choose from based on their preferences, such as a favourite colour.

Care workers understood the importance of obtaining consent from people before providing any care or support. They told us they would always seek consent. One care worker told us, "We ask people first. If they say no we try and encourage or support them to do things for themselves."

We observed the lunch time meal to help us understand how well people were supported. Prior to people being brought into the dining room, tables had been set with table cloths, cutlery and jugs of squash. Care workers supported people into the dining room where they sat at tables in small friendship groups of three to four people. Most people were independent with eating and drinking. One person required assistance from a care worker which was given without any interruptions and at the person's own pace. However, this was the only care worker present in the dining room which meant that another person, who was not eating their lunch, did not receive any prompts or assistance until the care worker had finished assisting the other person. The person was then offered an alternative of sandwiches as they did not want the meal they had been given initially. The registered manager explained this was unusual as there would usually be more than one care worker in the dining room. They advised us they would investigate the situation and take action to prevent this happening again. Two people had a 'fork mashable' diet following advice and guidance from a speech and language therapist. Where people were at risk of poor nutrition additional monitoring was in place, such as a monthly record of the person's weight and a daily record of food and fluid intake.

People gave positive comments about the meals provided at the home. One person commented, "I had a lovely lunch." Another person told us, "Lunch was very good but I am not very hungry." A third person said, "The meals are okay."

Care workers were well supported to carry out their caring role. One care worker told us, "I feel very supported. I can go and approach [registered manager] or [director]. I feel okay." Another care worker said, "I have the support I need." A third care worker commented, "Really good [support] by [registered manager] and the other staff." We viewed records of supervision and appraisal meetings between care workers and managers.

Care workers were supported to complete the training they needed. New care workers had completed the care certificate a part of their induction programme. This included all the essential training they needed, such as person-centred care, nutrition, safeguarding adults and infection control. Training records confirmed training was then updated when required.

Care workers gave us examples of the strategies they used in the home to support people when they displayed behaviours that challenged. For example, one person preferred to have quiet time. However, all care workers told us behaviours that challenged were not a particular issue within the home.

People were supported to access the health care they needed. Care records showed people had regular input from health professionals, such as community nurses, consultants, GPs and a chiropodist. One person told us about a specific health condition they had. They commented, "The nurse has been and there is nothing to worry about." One care worker commented, "We have lots of input from GPs and nurses. The mental health team also visit."

Good

Is the service caring?

Our findings

People gave us only positive feedback about their care. One person commented, "This is a very good home. The staff look after me." Another person told us, "I am quite happy, they do take care of you. The help I have had I can't fault them." A third person said the home was "so comfortable". A fourth person commented, "I am quite well taken care of."

People told us the care workers providing their care were kind and caring. One person described the care workers as "so friendly". They went on to say, "The staff are nice. Another person commented, "They are very kind, they are really, truly. They are so helpful. They do their best to help you." A third person told us, "You don't expect them to pamper over you but they do."

People were in control of their care and said they were listened to. They were also supported to meet their choices and preferences. One person told us, "If I said I wanted anything they would bring it for me." Another person said, "They don't say don't do this and don't do that. They don't force you into anything." A third person told us, "They come to us to see what we want." We observed one person asked if they could stay in the lounge to eat their lunch. Care workers said this was fine and arranged for a small table to be brought into the lounge for the person to use.

People were treated with dignity and respect. One person said, "They treat me just like anybody else." Another person commented, "The staff are all nice people. I am lucky to be so loved." Care workers gave us examples of how they promoted dignity and respect when providing care. For example, talking to people, keeping them covered up as much as possible, making them feel at ease and encouraging people do as much as possible for themselves. The registered manager told us treating people with dignity and respect was central to the ethos of the home. We saw this was a standard item for discussion at residents' meetings, staff meetings, supervision and appraisal meetings.

We observed care workers were kind and considerate towards people. We saw care workers checked on people and asked if there was anything they required. Staff interaction with people was always polite and friendly. For instance, we observed one staff member sitting with a resident and chatting about what they could have for their lunch. When caring or supporting people care workers explained what they were about to do and encouraged people to participate. People confirmed care workers promoted their independence as much as possible. One person commented, "They let me do as much as I can." Another person said, "I do what I can."

The provider followed the nationally recognised 'Six Steps' end of life programme to support people with making advanced decisions about their future care needs. Care records showed people had been given the opportunity to discuss their wishes. The registered manager kept a register to identify at which of the six steps people were currently at.

Requires Improvement

Is the service responsive?

Our findings

Care plans were not always detailed enough or up to date to reflect people's current needs. Two people's needs had changed so they were now sometimes now cared for completely in bed. Care plans for both people had not been updated to reflect this change or to describe how care workers should provide the care the people now required. For example, one person's care plan stated they were to spend time in day sitting in the communal lounge in a specific chair. The senior care worker told us this was no longer possible. We had no specific concerns about the person's actual care as community nurses were visiting very regularly to check on the person. The community nurse's notes stated people were receiving good care from the care workers employed at the home. By failing to ensure care plans reflected people's actual needs there was an increased risk people may not consistently receive the care they needed due to a lack of current information to guide staff and inform professionals about the care people needed.

Other care plans lacked detailed information to ensure care staff provided consistent care and support. For example, two people had been prescribed specific 'when required' medicines which needed care workers to make a judgment about when to give these medicines. The care plans for these people did not contain detailed guidance to help care workers make this judgment accurately. The care plans did not describe any other strategies for care workers to try first to avoid the need for medicines. This meant there was a risk people might not receive 'when required' medicines consistently and effectively.

Another two people had care plans to guide staff on their support needs when they displayed behaviours that challenged others. The care plan only provided basic information about the strategies which were most effective for each person. For instance, one person's care plan stated 'I will need reassurance everyday'. However, the care plan did not go on to describe what type of reassurance was the most effective for each person.

Risk assessments were not always personalised to the individual needs of each person. Care plans we viewed incorporated a risk assessment within the care plan. The risks identified tended to be general statements, such as 'loss of dignity', 'loss of self-identity' and 'loss of respect'. The assessments did not go on to identify how these general risk statements were applicable to individual people using the service. This meant we were unable to assess whether the measures identified in the care plans were appropriate to the needs and risks associated with people using the service.

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

Although some care plans lacked detailed information, other care records contained information about people's preferences. For example, each person had a 'one page profile' which gave information about what was important to them and how best to support the person. For one person this meant to have regular family visits and going out for a walk. Other information included food likes and dislikes, shower and bathing preferences and people's appearance. One page profiles are important as they help staff to develop a better understanding of people's needs. We found people's needs had been assessed both before and shortly after

admission to the home.

There were opportunities for people to participate in a range of activities. One person said, "I read a bit. I have been sat in the garden when it was nice." One staff member told us, "We try to keep people engaged with entertainment, birthdays, special occasions and some trips out." An activities book included photos of people participating in a range of activities and events. We observed on the afternoon of the first day of our inspection care workers organised a group game and one to one manicures.

Regular residents' meetings were held to allow people the opportunity to share their views. We viewed the minutes from previous meetings. These showed people were encouraged to express their opinions about the care they received. For example, during the most recent meeting people had confirmed care workers were "very nice to them" and that the meal choices had improved. One action from the meeting was to book an entertainer following discussions about activities.

People did not raise any concerns with us about the care provided at the home. One person said, "I can't complain, I have no complaints." They went on to tell us if they did have concerns they would speak with the [registered manager]. A third person commented, "I have no concerns, as long as I am treated well." People knew how to raise concerns. One person said, "All you have to do is see [director] or [registered manager] if you are worried." We viewed the complaints log which showed five complaints had been investigated and resolved.

Requires Improvement

Is the service well-led?

Our findings

We found the provider did not have an effective system of care plan audits in place. The concerns we identified with care plans had not been identified prior to our inspection. The registered manager wrote and evaluated all care plans. When evaluating the care plans for both people cared for in bed, the registered manager had recorded the care plan 'remains in place'. This was despite the person's needs having changed significantly. We found no evidence of any other checks or oversight on the quality of care plans to ensure they were fit for purpose.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had an established registered manager. The registered manager had been proactive in submitting the required statutory notifications to the CQC. One person said, "[Registered manager] is alright." Another person said "[Registered manager] is lovely, she is ever so nice. She is a very nice person. She will get anything for you."

The company directors carried out quality assurance checks on the quality of people's care. However, there were only two documented reports of these visits; one dated 2015 and a second audit dated August 2016 which focused mainly on the environment. Following our inspection the provider confirmed the Directors found it not necessary to formalise visits in writing other than the reports made available to us and when there was something of note. They went on to advise until recently they worked 'five days a week at the home and continually monitored and managed its running… on a more frequent basis than once a month, and continue to do so'.
Some other audits had been carried out. For example, a regular audit of medicines was completed. These had been successful in identifying and dealing with minor issues with medicines records.

At the time of our inspection daily records contained general statements about a group of people such as 'all residents assisted with personal care' or 'all residents had breakfast'. This meant it was not always possible to determine from viewing care records the individual care or support people had received from care workers.

People and care workers told us the home had a welcoming atmosphere. One person commented, "My family can come anytime they like." One care worker said, "The atmosphere is really good." Another care worker told us, "It is a nice place to be."

Care workers had opportunities to give their views about the care provided at the home. Minutes we viewed confirmed regular staff meetings took place. One care worker said, "Staff are really good, we have a good team. There is also lots of family input."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always planned in such a way as to meet their needs and reflect their preferences. Regulation 9(1) and 9(3)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to assess, monitor and improve the quality of the services provided were not consistently effective. Regulation 17(2)(a)