S L Crabtree

Park View

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Park View provides accommodation for up to 23 people who require help with personal care and people living with dementia. Bedrooms are located on two floors with access via a passenger lift. The home overlooks Lister Park in the Heaton area of Bradford. At the time of the inspection there were 22 people living in the home.

The inspection took place on 12 September 2017 and was unannounced

At the previous inspection, the service was rated Good and 'requires improvement' in well led. We identified a breach of Regulation 17 – Good governance. At this inspection we found the service retained the good rating overall and had made improvements to the governance of the service.

However at this inspection we rated the 'Is the service safe?' domain as Requires improvement. This is because we found some areas of the building required maintenance and adaption to ensure they provided a good quality environment for people living with dementia.

People told us they felt safe. We saw safeguarding procedures were in place and they were followed to help keep people safe. Risks to people's health and safety were assessed and clear plans of care put in place which were well understood by staff.

Overall, people's medicines were managed and administered safely although some improvements were needed to some staff practice.

There were enough staff employed to ensure people received a good level of interaction, supervision and companionship. Staff were safely recruited to help ensure they were of suitable character to work with vulnerable people. Staff received a range of training, support and supervision appropriate to their role.

People received a range of food which met their individual needs. Nutritional risks were well managed by the service.

The service was acting within the legal framework of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, best interest processes were followed. People were given choices and involved in decision making to the maximum extent possible.

People's needs were assessed and clear and person centred plans of care put in place, which were subject to regular review. People said care needs were met and staff were knowledgeable about people. The service worked with a range of professionals to ensure needs were met.

People said staff were kind and caring and treated them well. People were listened to and their views and opinions valued. Systems were in place to listen and respond to people's complaints.

People and staff spoke positively about the registered manager and said they were approachable. We saw they were hands on and regularly undertook care and support tasks which helped them maintain oversight of the home. Regular audits and checks were undertaken and people's feedback was used to drive improvements to the service.

We made one recommendation around maintaining and improving the quality of the environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some improvements were needed to the premises to provide a high quality environment.

Overall medicines were managed safely and people received their medicines as prescribed. Some minor improvements were needed to staff practice.

Risks to people's health and safety were assessed and used to develop appropriate plans of care to keep people safe. Incidents and accidents were recorded and investigated.

Is the service effective?

Good

The service remains Good

Is the service caring?

Good

The service remains Good

Is the service responsive?

Good

The service remains Good

Is the service well-led?

Good

The service remains Good

Park View

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 was also carried out to follow up on breaches of regulation found at the previous comprehensive inspection in October 2015. This inspection took place on 12 September 2017 and was unannounced. The inspection was carried out by three adult social care inspectors.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioning and safeguarding teams. We spoke with six people who were living in the home, a relative, five care staff, the cook, the registered manager, and the provider. We also spoke with two health and social care professionals who have contact with the service and a community pharmacist.

We observed care and support for several hours in communal areas of the home. We looked at elements of three people's care records, medicine records and records relating to the management of the service such as staff files, training records and audits.

Requires Improvement

Is the service safe?

Our findings

Overall we found the building was safe and retained a homely feel. We saw there were suitable numbers of communal areas for people to spent time spread across two floors of the building. This provided quieter and busier areas and gave people the choice of watching television, joining in activities or having some time alone. We found the building to be in a clean and hygienic state. We saw key safety checks were undertaken on the gas, electric and fire systems to help keep the building safe. An updated fire risk assessment for the building had recently been completed and arrived on the day of inspection. The provider informed us they were would work through any actions. Maintenance workers were employed who addressed any building defects. However improvements were needed to aspects of the premises to ensure a high quality living environment suitable for people living with dementia. There were patterned carpets and wallpaper throughout the building which can cause unnecessary confusion and distraction for people living with dementia. Some areas of the building required updating and wallpaper was peeling from some of the walls. There were some areas where floor coverings were stained such as in toilets. Push button taps were in place in some rooms which only stayed on for a few seconds which would be hard for someone with dementia to operate. We saw a plan was in place to address some of these areas of concern.

We recommend the service makes improvements to the premises to ensure a high quality environment fully suitable for people who use the service.

Overall medicines were safely managed. We saw staff administered medicines in a caring and patient manner, giving people the time to take their medicines and providing a drink with which to do this. We observed them knocking on peoples doors and asking, "Am I alright to come in and give you your medication?" Staff were able to give us information about various medicines and why they were prescribed in a confident manner. Staff were trained in the safe administration of medicines and had their competency checked. This gave us assurances about staff knowledge and skill.

However, we noted the staff member administering medicines broke off from their morning medicines administration to assist another member of staff with a person's care. We spoke with them after the medicines round and they told us this had been an error and they knew they should not have done this.

Most medicines were administered using a monitored dosage system to reduce the risk of error. We saw Medicines Administration Records (MARs) were well completed with no signature gaps, including for the administration of topical medicines such as creams. This indicated people were receiving medicines as prescribed. Some medicines are called controlled drugs. We found these were managed stored and administered safely.

A number of medicines were time specific. Some of these medicines were given at the correct time, such as medicines requiring to be given during or after food. However, we saw several people were given a medicine after breakfast which required administration 30 to 60 minutes before food. When we spoke with the staff member administering medicines they agreed they had forgotten on this occasion. We saw clear systems in place to ensure those who received medicines at morning and lunch time had a four hour gap in between

administration.

We saw protocols were in place for 'as required' (PRN) medicines. However, these needed to be more detailed to include information on indications and side effects. We discussed this with the registered manager and their responses gave us confidence this would be addressed. Safe stock control measures were in place. The person responsible for medicines administration counted boxed medicines each time these were administered, including when PRN medicines were offered. This ensured any discrepancies were identified and actions taken immediately. We checked a number of stock balances and saw these corresponded to what should have been present.

Medicines were stored safely and appropriate systems were in place for the safe ordering and disposal of medicines. We saw the service received support from the local pharmacy with staff training and audit of medicines. We spoke with the pharmacist who told us a recent audit had taken place which had not identified any issues. Senior staff were also responsible for monthly medicines audits and medicines were checked daily upon administration. This ensured any issues were promptly identified and actions taken.

There were enough staff to ensure people received a good level of interaction and supervision. People and staff told us staffing levels were safe. A person who liked to spent time in their room said staff responded quickly if they pressed the buzzer. One staff member told us, "They've got enough staff to go around; time to speak to people." During observations we observed there were staff present in communal areas, spending time chatting with people and engaging in meaningful activities. Staff did not appear hurried in their interactions with people. Rotas showed safe staffing levels were consistently maintained. These were responsive to individual need. For example, on the day of our inspection, another care staff member came on duty to support a person to a hospital appointment. The registered manager told us they did not used agency or bank staff and were able to provide safe care from the regular staff team since many were employed on a part time basis and were happy to pick up extra shifts. They told us, "It provides consistency for the people that live here."

We looked at staff recruitment records and saw staff were recruited safely. This included making appropriate checks such as Disclosure and Baring Service (DBS) and obtaining two satisfactory references prior to commencement of employment. A robust interview process was in place which included discussing gaps in employment and topics relevant to the role for which the candidate was applying. This gave us assurances staff had been checked to ensure their suitability to work with vulnerable people.

People said they felt safe living in the home and raised no concerns with us. Staff we spoke with had received safeguarding training and had good knowledge of how to recognise and act upon signs of abuse. We say appropriate safeguarding referrals had been made where previous concerns had been identified and these had been thoroughly investigated. We saw disciplinary procedures had been followed where issues with staff practice had been identified showing these matters were taken seriously by the provider.

Risk assessments demonstrated that risks to people's safety had been assessed in areas such as skin integrity and nutrition. These were appropriate and up-to-date, although we noted a number of nutritional risk scores had been incorrectly calculated, although the right action had always been taken to address these risks. Where risks such as falls were identified, measures such as low profiling beds and falls mats were installed and the advice of professionals such as district nurses sought to help reduce the risk. Incidents and accidents were recorded and investigated. We saw evidence these were analysed on a monthly basis to look for any themes and trends.

Good

Is the service effective?

Our findings

Staff had the right skills and knowledge to care for people. They received regular training via a variety of means including face to face, DVD's and distance learning. Training including food hygiene, nutrition, continence, end of life, safeguarding, MCA/DoLS, moving and handling, first aid and infection control. We saw staff were booked on training when courses became available, including upcoming courses on palliative care, diabetes awareness and infection prevention. Two members of staff were qualified to deliver a number of training subjects including moving and handling. We saw staff were encouraged to attend further training such as completing National Vocational Qualifications (NVQ). Staff told us the training was good and had equipped them with the necessary skills to provide people with safe and effective care and support.

We saw the provider had devised a pocket sized laminated information leaflet on MCA/DoLS as well as safeguarding information as an 'aide memoire' for staff. We found staff had a very good understanding of these topics, for example the conditions attached to a DoLS, indicating this and other training initiatives were effective.

New staff were subject to a three month probationary period which could be extended if required. When staff commenced employment, they received a week long induction which included training, reading care records, policies and procedures and completing a number of shadowing shifts. New staff also completed the Care Certificate. This is a government recognised scheme to provide staff new to care with the necessary skills for their role. New staff confirmed this and said they had been trained appropriately. We saw a comprehensive system of supervision and annual appraisal was in place. We saw these were used to discuss key topics such as training, development and any issues or concerns.

People praised the food provided by the home. One person said, "The food is very good." The home employed a full time cook and a relief cook for when they were not on duty or on holiday. We spoke with the relief cook who was able to provide us with information about people's diet and how they fortified food, such as with butter, cream and full fat milk, and made nutritious milkshakes for those people requiring extra nutrition. We spoke with them about the use of supplements and their answers gave us assurances people were receiving these as recommended. We saw information displayed in the kitchen about people's diets, food consistency and what food to avoid, for example with one person who had acid reflux. Our observations confirmed these guidelines were followed. People's weights were monitored monthly or more frequently if required and nutritional plans of care put in place. We saw appropriate referral to GP and dietician following weight loss and plans of care put in place to help boost nutritional intake.

People received a good variety of foods and were able to request an alternative if they did not want what was on offer. Menus were rotated on a four weekly cycle and included people's preferences which had been discussed at resident's meetings. For example, one person had requested hot chocolate with cream and marshmallows and this had been included as an option for the winter menu. We saw people had a choice of cereal, porridge, toast or a cooked breakfast in the morning, with the main meal served at lunchtime and a lighter meal in the evening. Food was home-made, using fresh ingredients and looked appetising and tasty.

Snacks were provided throughout the day including fresh fruit. We saw specific diets were catered for; for example, one person was provided with a halal diet in accordance with their preferences. People commented to us about the meals and told us these were very good. However one person who had their meals upstairs said that although the food was, "Alright," sometimes meals were a little cold.

We observed the mealtime experience and saw this was relaxed and unhurried. Staff sat with people who required assistance in order to offer support and gave gently encouragement. Staff interacted with people throughout the meal and explained the individual components of the meal they were receiving. We observed one person decline the desserts that were on offer so staff offered an alternative.

We saw a number of people used dementia friendly crockery which the provider had recently introduced. They told us staff had reported people using this were consuming a good diet which had not happened prior to this. We observed most people finished what was on the plates which confirmed this. We saw hot and cold drinks were provided throughout the day which ensured people were kept hydrated. One person told us, "I get enough drinks." People's nutritional and fluid input was recorded daily. However, although we saw people's fluids were mostly well recorded, some food charts were not fully completed with no indication about what food was consumed at lunchtime or for their evening meal.

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.

We found the service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had put in a number of DoLS applications, most of which were awaiting assessment by the supervisory body. One DoLS authorisation was in place, which had three conditions attached. The registered manager and staff were all clear of the conditions were and we saw evidence they had been complied with.

Where people lacked capacity we saw best interest processes were followed. For example one person had moved bedrooms following a best interest meeting. The rational for this was clearly recorded including evidence of discussion with a range of stakeholders, showing the move was in their best interest.

We saw evidence people's healthcare needs were assessed and appropriate plans of care put in place. The service worked with a range of health professionals to meet these needs including district nurses, community psychiatric nurses (CPNs) and GPs. Clear records were kept of conversations with health professionals and the outcomes of the visits. Two health care professionals complimented the communication from the service and told us staff listened and acted upon their recommendations.

Good

Is the service caring?

Our findings

People provided positive feedback about the home and the way they were cared for by staff. Comments included, "Its lovely here. As happy as you can be away from home", "Very good staff", "The girls are friendly and I get on with them", "They've been very good to me", "This place is lovely," and, "They are very good, very kind. There's a lovely cat."

We saw staff were kind and caring with people and treated them with affection and respect. For example, we saw staff knocked on doors prior to entering and asked permission prior to carrying out care tasks. The atmosphere at the home was calm and relaxed and staff spent time chatting and sharing jokes with people. Staff talked to people about their day, recent holidays and other topics which made for a friendly and inclusive atmosphere. Staff used a good mixture of verbal and non verbal communication to provide comfort and companionship and people looked comfortable and relaxed in the presence of staff. The registered manager told us, "I class it as a homely home." Staff demonstrated to us they had good, caring values. Through our conversations with staff they were able to explain how they maintain an individual's dignity whilst delivering care, for example covering the body as much as possible during personal care.

We saw good positive relationships had developed between people and staff. Care records were person centred and demonstrated the service had sought information about people's past lives to help better understand them and their needs. Staff and the registered manager demonstrated to us that they knew people well. The main dining lounge was supervised by staff throughout the day, providing continual companionship and encouraging people to participate in games and activity. There was no reliance on the television for entertainment with a high level of interactions, which were all positive. We saw staff reading magazines with one person and assisting another person to draw.

The registered manager told us that staff would accompany people to hospital either due to an emergency or routine appointment. They told us they did not charge people for this. This demonstrated a caring service.

A person centred approach to care and support was evident. People were able to get up at a time that suited them and have breakfast when they were ready. For example, we saw people had breakfast throughout the morning as they got up. People were listened to. For example, a large television had been purchased for one of the lounges following requests from people who used the service. Throughout the day, staff checked how people were and listened to their responses, responding to their requests for food, drink or activity. Throughout the home we found pictures on individual's doors to help them identify their room. Picture rotas were placed in the entrance hallway so people could see who was on duty. At meal times, pictures were placed on the wall to show people the food choices on offer. This helped promote choice and inclusion. We saw information was available to people on how to access an Independent Mental Capacity Advocate (IMCA) and we saw evidence that some people who had no family had been supported to access advocacy services.

Religion or belief is one of the protected characteristics set out in the Equalities Act 2010. Other protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity

status and race. We saw the service was acting within the Equality Act. For example, people had been provided with food appropriate to their culture and religion. We saw no evidence to suggest anyone who used the service was discriminated against and no one told us anything to contradict this.

Good

Is the service responsive?

Our findings

People said care needs were met by the service. A relative said their relative was, "Looked after well and they are happy which is the main thing." We asked staff about people's care and support needs. Staff were confidently able to describe people's plans of care and the measures put in place to ensure they received safe and appropriate care. This gave us assurance that care plans were followed.

People's care needs were assessed prior to using the service which looked at 16 areas of care and support to ensure the person's care and support needs could be met. These were then used to develop a range of comprehensive care plans in areas such as skin integrity, personal care, moving and handling and any religious or cultural needs or preferences. Care plans were subject to regular review to ensure they were kept up-to-date.

We saw care was delivered in line with plans of care. People were using equipment such as for pressure relief and falls prevention. Charts were in place which demonstrated people received regular checks and pressure relief in line with their plans of care. Although we saw staff were clear about people's pressure relief regimes we noted one care plan was missing information on the frequency of the person's pressure relief which meant there was a risk of inconsistent staff practice.

People had access to a range of activities. Staffing levels allowed staff to undertake activities with people throughout the day. This included planned activities, responding to people's individual requests and providing social companionship. There was a two week pictorial activities planner on display in the home. This included playing games, bingo, darts and musical instruments. Plans were being put in place for a Christmas party and some people were also going to the theatre to see a comedian. During our inspection we observed staff using a colouring book with some people as well as playing board games with others. Records from staff meetings demonstrated to us activities were regularly on the agenda and staff were informed activities must be completed daily and recorded in individuals care files. Staff told us on a monthly basis Holy Communion took place in the small lounge. One person cared for in bed also received holy communion in their room.

People said they were satisfied with the care and support provided and had no concerns. We saw the registered manager was visible and regularly undertook care and support tasks. This enabled people to regularly communicate with them over any concerns. Information on how to make a complaint was also available to people in the entrance of the home. We checked records and found no formal complaints had been made for the last 12 months. A complaints policy was in place although the timescale for responding to complaints was not included in the policy. We spoke about this with the registered manager who agreed to ensure the policy was amended to include this information.

Good

Is the service well-led?

Our findings

At the last inspection we rated the 'Well led' domain as requires improvement. At this inspection we found improvements had been made to the governance of the service with better oversight of areas such as nutrition and staff training and recruitment records.

A registered manager was in place. We found they had reported all required notifications to the Commission such as safeguarding incidents.

People spoke positively about the home and the way it was managed. People knew the registered manager who was 'hands on' and regularly undertook care and support tasks. This helped them monitor how the service was operating. They were able to confidently answer questions we asked them about people which demonstrated to us they had good oversight of people and their changing needs.

Staff commented they felt supported by the registered manager and were able to approach them or a member of the senior management team if they had any concerns. Morale was good and staff appeared confident in their roles. There was a positive culture within the home.

Systems to assess, monitor and improve the service were in place. This included a range of audits and checks. In order for the provider to monitor these were being completed in a timely manner, a notice board had been created in the registered manager's office where the date of each monthly audit was inputted. This allowed the provider to effectively monitor the registered manager's activities. The provider conducted monthly monitoring visits and a short report was produced detailing actions to further improve the service. The registered manager and senior care workers conducted checks and audits in areas such as care plans, medicines management, staff training, nutrition, health and safety and equipment.

Staff meetings were held regularly and seen as an opportunity to discuss specific topics such as safeguarding. Staff told us they felt able to speak out at these meetings about any concerns or issues and felt they would be listened to.

We saw surveys had been sent to people living at the home and responses were generally positive. Where comments had been made about improvements, such as menus and activities, we saw these were put on the agenda of the residents meetings. Regular resident meetings were held where people were given the opportunity to be involved in the day to day running of the service. For example, we saw people were consulted about the upcoming winter menus and activities. Following the meetings we saw actions were taken to put these into practice where possible. For example, the winter menu included curries, pasta dishes and hot chocolate with cream and marshmallows which had been requested during these meetings. We also saw further activities such as trips to the theatre were incorporated into the activities planner. This meant people's views were listened to and actions taken as a result.