Parkview Residential Home

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Inspection report

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Date of inspection visit:
29 November 2022

Date of publication:
13 January 2023

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Parkview Residential Home is a residential care home for 22 people with conditions associated with old age including dementia. There are bedrooms on the ground and first floor. There is a communal lounge and dining area located on the ground floor. At the time of our inspection there were 15 people living in the service.

People's experience of using this service and what we found
People were at risk of receiving unsafe or inappropriate care. The current systems in operation for the management of medicines was unsafe. Care records were not always reflective of people's needs and risks. One person's risk identified by the service had not been escalated to healthcare professionals so the Care Quality Commission (CQC) raised a safeguarding alert.

We identified some concerns around the overall management of the service environment. The fire risk assessment in use by the service at the time of the inspection was historical and emergency evacuation plans were not available which was not in line with the provider's policies. This placed people at risk of harm.

There were no formal systems to review incidents and accidents, placing people who may have evolving care and mobility needs at risk. If the provider had an effective system in place this may have prevented further falls by the same people so patterns and trends could be identified. Records relating to falls and accidents during a specific period of time could not be located by the service management. We identified some staff had not been recruited in line with legal requirements.

There was a significant lack of understanding around the Mental Capacity Act 2005 and how it was applied in the service. There were no effective systems in place that ensured that where required, people who may need applications to be submitted to lawfully deprived of their liberty were completed. This meant there was a risk the service were unlawfully depriving people of their liberty. However, people were supported in day to day decisions by staff who worked in their best interests.

The provider had failed to ensure training appropriate to the needs of people living at the service had been adequately provided. This placed people at risk of receiving unsafe or inappropriate care that was not in line with best practice. We have made a recommendation about the current training provision.

People told us they received personalised care and observations we made supported this. However, the records being used did not always reflect people's current care needs or evidence a fully person centred approach to achieving the best outcomes for people. Improvements were needed around end of life care planning to ensure it was consistent throughout the service for all of the people being supported. There was no understanding of the Accessible Information Standard to which providers of publicly funded adult social care services must meet. We have made a recommendation about the Accessible Information Standard.

Current governance systems in operation to ensure the health, safety and welfare of people using the service and others were inadequate. There was insufficient auditing of care records, environmental risks, medicines, training and Mental Capacity Act 2005 compliance. The service was clean and domestic staff completed cleaning schedules but the provider had no oversight through an infection control audit. Where audits had been completed, for example for medicines, they were not effective in improving the service or making changes to current practice which placed people at risk. The provider had also failed to notify CQC in full about any significant events at the service in line with regulatory requirements.

People told us they felt safe at the service and the feedback we received about the staff and provider was positive. People were kept safe from harm as staff knew how to identify and report safeguarding concerns. Visitors were able to enter the service in line with current guidance. The staff at the service worked well with other health professionals.

People and their relatives spoke positively of the caring staff that supported them. One person told us, "The staff are very caring here, I really enjoy being here." A relative told us, "I really can't praise them enough here, they provide some amazing care." We reviewed the compliments the service had received and we saw peoples' records were stored confidentially to promote their privacy.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 16 March 2019).

Why we inspected
This inspection was prompted by a review of the information we held about this service. There had been a low number of statutory notifications received from the provider. A statutory notification contains information about certain incidents and events the provider is required to notify us about by law. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, good governance, fit and proper persons employed, need for consent and the failure to send statutory notifications to the CQC as required by law. We have also made a recommendation around training provision and the current systems in place for complying with the Accessible Information Standard.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow Up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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? The service was not safe.	**Inadequate**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service caring? The service was caring.	**Good**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Parkview Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one Inspector.

Service and service type
Parkview Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Parkview Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. There was also another manager appointed who was involved in the day to day management of Parkview Residential Home. We have referred to them in this report as the service manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the Provider Information Return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also reviewed additional information we held about the service, this included previous inspection reports and statutory notifications. A statutory notification contains information about certain incidents and events the provider is required to notify us about by law.

During the inspection
We spoke with five members of staff which included the provider, the service manager and care staff. We spoke with seven people who lived at the service, one person's relative and observed some interactions between people and staff.

We reviewed a range of records, including peoples' care records, staff recruitment files, records relating to safety checks including fire safety and accident and incident records. We also reviewed medicine records and records relating to monitoring and quality assurance.

Following our site visit, we requested feedback from three healthcare professionals but did not receive any response. We also received further clarification and documentation from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- The systems to order, store, administer, audit and return medicines were inadequate and this placed people at risk of harm.
- Medicines were stored securely; however, we found an example of where an opened liquid medicine was not dated to show when it was opened. There was a risk it could be used past its recommended period after opening. This meant people were at risk of medicines being administered that were no longer effective.
- Where handwritten entries had been made by staff on Medicine Administration Records (MARs) we found these had not always been countersigned. The provider had not followed published guidance, including that by the Care Quality Commission (CQC), about accurately recording handwritten MARs entries safely and accurately. This presented a risk the handwritten entry may be inaccurate and expose people to harm of the dose of medicines being incorrectly administered.
- Where people were prescribed medicines to be taken 'as required', for example pain relief, protocols were not completed. In some examples there were no records showing what the strength of the medicine was, how it was taken, why it was taken and key information such as the maximum daily dosage required or any special instructions associated with the medicine. This placed people at risk of not being administered the correct amount of prescribed medicine when they were in pain.
- An audit undertaken in June 2022 identified the service did not have a current British National Formulary (which aids prescribers, pharmacists, and other healthcare professionals with sound up-to-date information about the use of medicines) and this had not been addressed at the time of inspection. Additionally, the audit asked if staff had access to published guidance from The Royal Pharmaceutical Handling of Medicines in Social Care and CQC. The audit in June 2022 identified this as a shortfall but no action had been taken to rectify this. Therefore, best practice was not followed. For example, MARs did not consistently have photographs of each person prescribed medicine. The service manager said this was addressed the day after the inspection.
- Where risk in relation to medicines was evident, action had not been taken to minimise potential harm. For example, a risk assessment had not been undertaken in relation to the potential risks associated with the flammable topical body lotions being applied to a person who smoked. The provider had again failed to follow published guidance in relation to this risk.
- Staff completed an online training programme in relation to administering medicines. The service manager said they observed staff to check their competency in medicine administration. However, no written records of any staff observations were made to support this.
- We identified the service manager had not completed medicines training in over 18 months and there was no record the provider had assessed their continuing competency. This did not evidence safe practice by the provider.

Assessing risk, safety monitoring and management

● People were at risk of receiving unsafe or inappropriate care as care records did not always reflect their current needs and safety monitoring was not always completed.

● Where people's risks were assessed, records did not always reflect their current needs. For example, the service manager told us that they were modifying the diet of one person and on occasions blending food, as the person was struggling to swallow some food and spat food out. No escalation had been made to any health professional about this. We raised a safeguarding alert in relation to this and the service made an urgent referral to the person's GP as potentially the person could have been at risk of choking or was in pain.

● Known risks were not recorded and neither was a relevant support plan in place. Some people at the service had behaviours that may challenge. We made observations of these challenging behaviours. There was no behaviour support plan or care plan to aid staff in such situations and reduce any risk or distress to the person. This placed the person at risk of inappropriate or behaviour escalating care interventions.

● For another person that demonstrated challenging behaviour, there was no identified outcome in their care plan. The outcome section of the behaviour section of the care plan read, 'I try to manage my behaviour'. There was no support plan to aid staff placing the person at risk of inappropriate or unproductive care interventions and no description as to how the person could manage their distress.

● People had individual emergency plans in place to ensure people were supported to evacuate in the event of a fire. However, these had been recorded electronically and were not in the fire 'grab bag' to enable emergency services to access them should they be needed. This was unsafe practice and did not follow the provider's health and safety policy dated February 2022.

● The fire risk assessment shown to us was dated 2008. The service manager advised us during and following the inspection this was the most recent document. Six days following the inspection the Care Quality Commission (CQC) were sent a fire risk assessment dated December 2022 evidencing there was no new fire risk assessment completed between 2008 and 2022, a period of 14 years. This did not show an effective system was in operation to ensure the risk assessment was still accurate.

● Environmental safety monitoring was not safe. There was a delay in the service manager providing us with environmental risk assessments and monitoring records, for example window restrictor checks and bedrail assessments. We received some documentation relating to this however the provider advised us the current system would be reviewed.

● We requested the electrical safety certificate for the service and saw that portable electrical appliances were tested and mobility equipment was serviced. However, the gas safety certificate could not be located by the service manager. Following our visit, we received a new gas safety certificate showing servicing was completed seven days after the inspection. It was therefore unclear if the annual gas safety checks had been completed as required.

Learning lessons when things go wrong

● There was no formal system to ensure accidents and incidents were monitored by the service management to identify any patterns or trends.

● During the inspection we reviewed the falls recorded over the previous 12 months and identified incidents where the same people had fallen repeatedly, some of which resulted in injury. A system in operation to identify patterns or trends to people may have prevented these injuries and reduced the risk of harm to people.

● Staff told us how they reported any falls or incidents via an incident recording notepad. However, it was not evident this information was used by the provider or service manager to keep people safe.

● We reviewed one persons' care records. We found their hospital discharge record that showed they suffered a fracture whilst living at the service in December 2021. There was no corresponding record in the accident book and the service manager was unable to locate and produce the record during the inspection. This showed records were not made or retained in line with legal requirements.

● During a review of the accident and incident records, we identified reporting books did not run in any chronological order. For example, the current accident reporting book had six entries between October 2020 and December 2020. The next entries related to November 2022. There was an evident period of time where no records could be accounted for between August 2022 and November 2022. The service manager could not locate the records covering the period from August 2022 to November 2022.
● The current absence of any adequate system to record, respond to and monitor accidents and incidents was also in contravention of the provider's own health and safety policy.

Whilst we did not find significant impact to people, the current system in operation for the management of medicines was unsafe and presented a risk to people at the service. Inaccurate records relating to the delivery of care presented a risk to people's safety. The failure to effectively monitor incidents and accidents and current safety management of some aspects of the service environment and building presented to a risk to people and staff. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited in a consistent safe manner. Relevant pre-employment checks had not always been carried out in line with the requirements of the Health and Social Care Act 2008. On reviewing two staff members' files the provider had failed to ensure full employment histories had been obtained as required. Within one person's recruitment file the dates of employment on the references did not correspond with that on the staff member's application form. This placed people at the risk of inappropriate staff being employed.

Whilst we did not find significant impact to people, unsafe recruitment processes presented a risk to some people. This was a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were sufficient staff on duty to meet people's needs. A person told us, "It's an ok to place to live - I get the things I need."
● There had been recruitment challenges within the service in line with the current national picture in health and social care. New staff had recently been recruited which current staff told us was a very positive step forward.
● Staff gave mixed feedback on the staffing levels. Whilst in general staff told us there were sufficient on duty to meet people's needs, some commented that the afternoons could be very busy and people have to wait. A staff member also commented that if there was some form of emergency they didn't feel there may be enough staff to meet people's needs, whilst also tending to an emergency situation.
● Relatives told us they felt there were sufficient staff on duty to care for people.
● The service operated a set number of staff throughout the day to care for people and also employed additional staff. such as housekeeping and catering staff.
● There was currently a small reliance on agency staff at the service, but the provider had ensured the same agency staff were used to promote care continuity.
● During the inspection, we observed call bells were responded to promptly.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse as staff knew how to report concerns within the service and how to raise concerns with external agencies.
● There were policies in place for staff to follow and safeguarding reporting information was located in communal areas of the service for people, staff and visitors to see.

● People were evidently at ease in the company of the staff team and all of the feedback we received about the staff was positive. One person told us, "Can't fault the place and all of the staff make it what it is."
● Staff confirmed they had received training in safeguarding, however we noted on the training matrix supplied by the service manager some staff needed training in this area.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date, however the service manager had not completed infection control audits.

Visiting in care homes
● People were supported to see visitors in line with current UK Government guidance.
● People's families told us they were supported to visit in a safe way and felt welcome when visiting.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● During the inspection we identified there was no evident understanding by the provider or service manager in relation to the MCA or DoLS. As previously highlighted in this report, no formal training had been provided and this had impacted on outcomes for people.
● At the time of our inspection, there were no people living in the service that had an authorised DoLS. The service manager had not made any applications and there were no applications outstanding with the relevant local authority. This placed people at risk of being unlawfully deprived of their liberty.
● Within people's care records, we saw the service had recorded some people were diagnosed with dementia and others had a Lasting Power of Attorney (LPA) acting on their behalf for both care and finance. The service had not recognised that this potentially indicated a lack of capacity to consent to care or treatment or to live at the service, meaning a DoLS application may be needed.
● Training in the legal framework underpinning care and treatment for people who may lack capacity was not provided. There was no training provision in The Mental Capacity Act 2005 (MCA) or the Deprivation of Liberty Safeguards (DoLS) which is significantly important legislation when supporting people who may lack mental capacity. This meant there was a significant risk people may not be cared for in line with the law and may be result in them being unlawfully deprived of their liberty.
● Staff we spoke with did not understand DoLS and how it impacted on their work and were not aware if anyone in the service was subject to a DoLS authorisation. When asked about DoLS, one staff member commented, "I'm not entirely sure about that."

● We saw that for some people the service had completed a capacity assessment as a 'blanket' determination of the person's capacity which was not in keeping with the principles of the MCA. Additionally, where best interest decisions had been recorded, these were not always specific in what the best interest decision was being made about.

Whilst we did not find significant impact to people there was a risk of people receiving unsafe or inappropriate care that was not aligned to best practice. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● The current training provision for staff from the provider did not ensure that basic training to support staff in providing care to people with specific health conditions was available.

● Some people at the service were living with dementia and some presented challenging behaviour. There was currently no staff training provision in place for either dementia or challenging behaviour which placed people at risk of unsafe or inappropriate care that was not aligned to best practice.

● During the inspection, we made observations where staff supported people that were presenting challenging behaviour evidencing training in this area was needed. Care plans for some people had also identified the behaviours some people displayed.

● We requested information relating to the food hygiene training undertaken by the provider who was currently supporting in the service by cooking in the kitchen. We received a certificate that showed this training was completed after the date of the inspection. This showed the training had not been completed prior to the provider supporting in the kitchen environment.

● Staff commented they felt additional training was needed. A staff member commented on how they would like training in dementia to help understand some of the people they cared for.

● The provider had not provided training in end of life care provision which a staff member said would be beneficial. This would help to ensure people at the end of their lives could have a dignified and pain free death that was in line with their wishes.

● Induction for staff new to the care industry included attaining the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● There was a system for staff supervision to be completed, but the service manager told us this was currently being disrupted with staff shortages and the requirement for them to work on the floor. Staff told us they felt well supported by the service manager in relation to supervision and being able to communicate with them about their job role within the service.

We recommend the provider seeks advice and guidance from an accredited source to ensure the training provision within the service is specific to the needs of people who live there.

Adapting service, design, decoration to meet people's needs

● People had individual rooms with some having an en-suite toilet. People also had access to a communal bathroom and additional toilet facilities.

● Additional communal areas were available for people to use. The service benefitted from a large lounge and dining area. There were communal garden areas and internally some separate areas meant people could meet privately with visitors.

● There was a chair lift in operation to support people to access the upper floor for people that needed it.

● Communal areas such as the toilets had clear signage on them to aid people in navigating around. Handrails were fitted for people to support independence.

● People had individualised rooms. People's rooms were personalised with items such as family pictures and ornaments.
● We saw that in the lower corridor where some people's bedrooms were located, there was a raised area of carpet that could be a trip hazard to people walking independently or with an aid. This was highlighted to the service manager to be actioned.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were assessed prior to moving into the service to ensure their needs could be met and that the environment was suitable for them.
● The service manager told us that prior to the Covid-19 pandemic people would be visited by service staff to complete an assessment of their needs. The service currently worked in partnership with the local authority and families for pre-admission processes.
● Nationally recognised tools in relation to skin integrity or identifying a risk of malnutrition were used within care plans, however as highlighted within the report these were not always current or reflective of people's needs.

Supporting people to eat and drink enough to maintain a balanced diet
● People did not raise any concerns about the food they received. All of the feedback we received was positive. One person told us, "The food here is good and I enjoy eating it." Another comment was, "The food is very good, they go above and beyond for me here."
● There was a menu that ran over a four week cycle and the service had dedicated catering staff. People could also choose something of their choice if they didn't want what was on the menu.
● People were supported with hydration. People were observed being offered choices of drinks and there were drinks available to people in their rooms.
● Healthcare professionals we spoke with did not raise any concerns in relation to the nutritional support people received. Where people were prescribed supplements to increase their caloric intake, these were given as prescribed.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
● People had access to a variety of healthcare services and professionals according to their needs, which was confirmed by people living at the service.
● People were registered with a GP for appointments and advice as needed. On the day of the inspection we saw a member of the local district nursing team and an occupational therapist attended the service to see people.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. The rating for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People were cared for by staff who were committed to their roles and wanted to achieve good outcomes for them.
- Staff told us they worked well together and that this was a key part of being able to provide good care. One staff member commented, "Between us we have lots of experience and it's all about doing the best for people. We work very well together as a team; you have to make it work for people."
- People were positive about the care they received and the staff that supported them. One person told us, "I love living here, I get on really well with the staff." Another person commented, "The staff are very caring here, I really enjoy being here."
- Relatives spoke positively about care provision and staff. One said, "I really can't praise them enough here - they provide some amazing care."
- A selection of compliments received by the service were reviewed. One read, 'Thank you all so much for making [person's name] stay a happy one, I can see he is well looked after.'
- During the inspection people and their relatives told us how the service had made birthdays very special. The service manager told us a tea party was held for people in the communal lounge area on their birthday.

Supporting people to express their views and be involved in making decisions about their care

- People told us they received care how they wished and in line with their preferences. During the inspection we made observations to support this. People were given different choices of food, drinks and what they participated in.
- People told us they could do as they wished which supported the observations we made during our inspection. One person commented, "They are very good to here and look after us, we can do what we like here." Another comment we received was, "The staff are lovely, I couldn't ask for more."
- We observed staff offering people choices and people were communicated with respectfully. Interactions were tailored to the individual and were person-centred in their approach.

Respecting and promoting people's privacy, dignity and independence

- People's privacy and dignity was respected. We observed positive interactions to support this during the inspection.
- Staff gave examples of how they promoted independence and we made observations to support this. This included by knocking on doors and supporting them in a dignified way during care and support interventions.

● We observed that people were supported to be as independent as possible. Examples included where staff supported people to mobilise and then allowed them to walk independently using their walking aid whilst discreetly walking near them.
● The service had ensured that people were afforded privacy when being visited. In addition to people's bedrooms, there were private areas situated around the ground floor people could spend time alone with people that visited them.
● Records within the service were maintained confidentially. Care plans in the service were electronic and any hard copy documentation relating to people's health and care needs were within access controlled areas.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant there was a risk people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- During our observations we found that staff met people's needs, however care plans for people required further information and detail to aid in delivering person-centred care.
- Every person at the service had a care plan, however these plans were not always reflective of their current needs and lacked detail. This meant there was a risk care would not always be responsive.
- Within care records there was a section that allowed the service to record their desired outcomes for people in relation to different aspects of their lives. The care plans had failed to explore in any depth what positive outcomes could be achieved and were not meaningful. For example, for one person who demonstrated challenging behaviour, their outcome section read, 'I try to manage my behaviour.' In another person's mobility care plan, where it was identified the person mobilised with the use of a mobility aid, the outcome for the person read, 'I am well' and had no information relating to the outcomes relating to their mobility.
- Within another person's mobility care plan, it identified the person was at high risk of falls but did not detail the person had previously fallen and was currently receiving clinical support from the district nursing team due to the injury sustained.
- Whilst it was evident care plans required development and for people's needs to be recorded in a more person-centred way, people we spoke with felt their care was personalised. One person told us, "The staff are nice to me, we have a laugh." Another person told us of the great relationship they had with the provider. A relative told us, "I have no concerns here, [person] is very well cared for."

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The AIS tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- Whilst we were unable to identify any direct impact on people, it was not evident the AIS had been considered or embedded within the service. The service manager was not aware of the AIS or how it could be used an implemented within the service.

We recommend the service seeks advice and guidance from an accredited source to ensure the AIS is understood and embedded in the service where required.

End of life care and support

● Whilst we did not identify any impact on people, care and planning to support people at the end of their lives was not always recorded consistently within people's care records.

● At the time of our inspection, there were no people within the service currently assessed as nearing the final stages of their life.

● Care records did not consistently evidence that people had records relating to their end of life wishes. For example, some records had an end of life care plan and others did not. This meant should a person's health decline rapidly, the service may not be aware of or be able to act in accordance with the person's end of life care wishes.

● There was an inconsistent approach to providing personalised end of life care. For example, in one person's care records, they had highlighted what music they would like to listen to at the final stages of their life, and who they would like to be present. Other care records did not contain any end of life information or evidence any such conversation with the person or their representatives had taken place.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People had opportunities to be involved in activities. The service manager told us that the current staffing issues had impacted on being able to have a structured programme. Staff were currently providing activities on top of their care roles.

● People did not raise any concerns about how they spent their day. People spent time together as a group in the communal area and there was a good level of socialising and interaction.

● Comments we received from people included, "I have enough to do here, I can take part [in activities] if I want." Another person we spoke with told us, "There's enough to do, we are always up to something."

● When activities were on, people told us they could choose if they wished to join. On the day of the inspection there was a reminiscence/memory game with a ball in the morning and decorating festive decorations in the afternoon. People that indicated they didn't wish to join in had their wishes respected.

● People had visitors to support them to avoid being socially isolated, which occurred on the day of our inspection. Some people in the service had their own mobile telephones and used them to keep in contact with family members.

Improving care quality in response to complaints or concerns

● The service held an appropriate complaints policy and procedure. The policy and procedure detailed how complaints or concerns would be handled.

● There was information on how to make a complaint situated in the entrance foyer of the service for everyone to see.

● The service manager told us no formal complaints had been received in a significant period of time.

● No concerns were raised about making a complaint by people or relatives. One person we spoke with told us, "I certainly have no complaints here."

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The current governance arrangements at the service were inadequate and we identified significant shortfalls within the leadership and oversight by the service manager and provider. This placed people at risk of unsafe or inappropriate care.
- There were currently no effective systems to monitor the health, safety and welfare of people at the service. The management of the service environment was not safe. There was an absence of effective oversight at both service management and provider level.
- We have identified breaches of regulation during this inspection that have, in part, resulted from inadequate governance. For example, medicines management was currently unsafe presenting a clear risk to people. The service manager completed an audit in relation to medicines but we identified significant shortfalls evidencing an ineffective audit. This was further compounded by the provider's failure to provide adequate training and competency assessments for the service manager to ensure their competency in medicines management.
- The risks associated with people's health and care needs, for example their behavioural needs or those at significant risk of choking had not been identified through any effective monitoring system. This placed people at risk of harm.
- The absence of monitoring care records had also resulted in care records being produced that did not focus on the outcome for people in the service in relation to their health, care and end of life needs and preferences.
- Failure to implement and effectively use a system to monitor incidents and accidents exposed people to the risk of harm. Had an effective system been in place, some people may not have repeatedly fallen and sustained further harm.
- Whilst we identified the service was clean and domestic staff completed cleaning schedules, there was no service management or provider level auditing undertaken of the service environment. This lack of oversight presented a risk that nationally published infection control requirements were not adhered to.
- There was no oversight of training provision to ensure appropriate training for staff was provided to meet the needs of people at the service. This placed people at risk of receiving unsafe or inappropriate care that was not in line with best practice.
- Current governance arrangements and leadership understanding had not ensured the documentation relating to the Mental Capacity Act 2005 had been appropriately completed. In addition, there was a risk that people within the service were or would be unlawfully deprived of their liberty as Deprivation of Liberty Safeguards application had not been made. The provider had failed to ensure both management and staff

had received training in this critical legislation.
● The failure to ensure the service environment such as completing environmental risk assessments placed people and staff at risk. Additionally, the fire risk assessment produced at the inspection was 14 years old. Emergency evacuation plans were not available in the event an evacuation was required which placed people at risk. The absence of an audit or oversight had failed to identify this.

The inadequate and ineffective governance arrangements may present a risk people and staff at the service. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had failed to notify CQC in full about any significant events at the service in line with regulatory requirements. During the inspection we identified the provider had failed to send serious injury and safeguarding notifications. CQC use this information to monitor the service and ensure they respond appropriately to keep people safe and the absence of reported data may not ensure effective regulation can take place.

The failure to notify CQC of deaths and a serious injury in line with requirements was a breach of Regulation 18 of the Care Quality Commission (Registration Regulations) 2009.

●The provider had ensured that the current performance ratings were displayed within the service and on the providers website in line with regulatory requirements.

Continuous learning, improving care and working in partnership with others
● As highlighted above, there was no current system to review incidents and accidents to reduce the chance of recurrence and learning. This meant the service were not identifying opportunities to continually learn, adapt to reduce risk and improve care.
● The service management had community links prior to the Covid-19 pandemic. We spoke with the service manager about any current or projected community links. The service currently was currently visited by a representative from the local library who attended weekly. The local vicar had been contacted with a view to restarting services.
● Arrangements were in place for the Christmas period. A musician was attending to hold a carol service with people. In addition to this, some residents will be attending the local primary school to watch a nativity. Pupils from the same school will also be attending the service to sing for the people living there.
● Staff and the service management worked with other professionals to ensure people's needs were met appropriately. The registered manager commented positively on their relationship working with other professionals. We observed on the day of the inspection that staff engaged well with healthcare professionals who attend the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; how the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People, their relatives and staff did not raise any concerns in the leadership at the service and about the way the service was managed. We saw that the service manager and people communicated well together. Some people we spoke with were very complimentary of the service provider and told us how they had gone above and beyond for them.
● Staff generally spoke of a positive working environment, but all commented on the challenges with staffing and recruitment. We had good feedback in relation to teamwork and how it supported people at the

service. One staff member told us, "We work very well together as a team - you have to make it work for people."

● We received mixed feedback when we spoke with some staff about if they would recommend Parkview Residential Home to others to live. Whilst some told us they would recommend others were slightly more hesitant.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There were no formal systems currently in operation to seek continuous feedback from people, their families and staff. The service manager told us this was achieved on a daily basis through conversation and interaction with people. We made observations to support this.

● Whilst there were no formal systems to record staff feedback through surveys, staff felt communication in the service was good and we observed minutes to show that periodic meetings were held. There was a communication book to record and share key messages.

● Staff told us both the service manager and the provider were approachable and they felt they would be listened to if they made suggestions about the service. One staff member told us, "They are good to work for and no issues. They seem good bosses." When discussing the service manager one staff member commented, "Their approach is very helpful but she's also very patient."

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to send to send statutory notifications as required. Regulation 18(1)(2)(ii)(iii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to act in accordance with the 2005 Act and provide relevant training for staff. Regulation 11(1)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to operate safe and effective recruitment processes. Regulation 19(3)(a)