Runwood Homes Limited

Park View

Inspection report

Priory Road
Warwick
Warwickshire
CV34 4ND

Tel: 01926493883

Date of inspection visit:
13 December 2017
18 December 2017

Date of publication:
12 February 2018

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 13 December 2017 and was an unannounced visit. We returned on 18 December 2017 so we could speak with more staff and look at their quality assurance systems.

At the last inspection on 14 November 2016, the service was rated as requires improvement. This was because we found a lack of managerial oversight by the provider and the management did not operate effective audit systems to drive improvements within the service. We found monitoring of people's food and fluid intake was not always consistent with what they had consumed. Actions were not always recorded to show how people were supported and audit systems had not identified this as a concern.

Following the last inspection visit, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Effective and Well led to at least good.
This inspection visit was a comprehensive inspection and during this inspection we checked to make sure improvements had been made. Whilst some improvements had been made, we found some improvements were still needed in their audit systems because they had not identified some of the improvements we found.

Park View is a care home registered to provide care to 64 people. People in care homes receive accommodation and nursing and/or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection visit, 54 people lived at the home.

A requirement of the service's registration is that they have 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 and the associated Regulations about how the service is run. At the time of our inspection visit there was no registered manager in post. The registered manager had left the service in July 2017. Since then a manager has been in post, and in December 2017, had applied to become the registered manager at the home.

People told us they felt safe at the home, because they felt safe with the staff who supported them. Staff had received training so they understood what might constitute abuse and the action they should take to safeguard people if they had any concerns.

The provider used recognised risk assessment tools to identify any risks to people's health and wellbeing. Staff knew how to support people to reduce identified risks to people. However, some risks to people had not always been mitigated to prevent further risk,

People told us their needs were met because they were supported and cared for when needed. People were complimentary of the staff and said staff were kind, caring and considerate in their approach. People spoke

positively about the friendliness and willingness of staff to help them.

People told us they had a choice of meals and could eat in the dining room or their own bedroom, according to their individual preference.

People's privacy and dignity was respected and staff knew how to maintain this to prevent people feeling uncomfortable. Staff promoted people's choices and independence which gave people a sense of worth and ownership in how their care was delivered.

The home was clean, free of odour and staff wore personal protective equipment (PPE) at the necessary times. Regular spot checks and effective monitoring ensured standards of cleanliness were maintained.

People told us they would feel happy to raise any concerns or complaints and they knew how to do this and expected timescales regarding a response.

There were enough staff who were available to provide people's care and support at times people preferred. Staff respected people's privacy and dignity and people felt comfortable when staff supported them to maintain their health and wellbeing.

Medicines were administered safely and people received their medicines as prescribed. Time critical medicines were given at the required times and PRN protocols ensured staff provided those medicines as and when required, safely.

The audit systems required improvement to ensure actions led to improvements. We found examples where food and fluid charts were incomplete, but we satisfied action was taken to support them if a concern was known. Where checks were delegated to others, there needed to be greater scrutiny to ensure improvements to the delivery of service were made.

Recent management changes meant not everyone knew who was the permanent manager, however people were complimentary of the manager and their approach. The manager was committed to improve the service and wanted people's experiences to be positive. The manager gave us a commitment that actions would be taken. When we discussed improvements with the manager, when we returned on the second day, an action plan was in place to improve the standards within the home.

The registered manager had submitted a Provider Information return (PIR) to us, they and the provider understood their legal responsibility to notify of us of important and serious incidents. The provider displayed a copy of their previous inspection rating.

Further information is in the detailed findings below.

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 always safe.

People felt safe living at the home and they were supported by enough staff who were available to provide their care and support at times they preferred. Potential risks to people's health were assessed but did not always mitigate some risks in how they were managed. Staff understood how to recognise abuse and how to report it. People received medicines from trained staff with checks completed to ensure medicines were administered and stored safely. The registered manager analysed incidents, accidents and complaints which resulted in minimising the risks of further similar issues re-occurring.

Is the service effective?

Good

The service was effective.

At the last inspection we found food and fluid charts were not always completed accurately, and in some cases, did not support what people had consumed. At this inspection we found some still were not updated, however improvements were made. Staff supported people in line with the MCA and staff respected and promoted people's choice and independence.

Is the service caring?

Good

The service was caring.

People and relatives were very happy with the care and support they received. People said staff were patient, caring and helped them be cared for in a way they preferred. Staff had caring attitudes and personalities that responded well to people they supported. Staff respected and understood the importance of respecting people's privacy and dignity and supporting those who were able, to remain as independent as possible.

Is the service responsive?

Good

The service was responsive.

Staff supported and encouraged people to maintain their

interests and consideration was given to individual's wishes to strengthen and personalise the activity programme. Staff knew people well and involved them in agreeing their care and support needs. End of life care was planned for when needed to limit delays in receiving appropriate health interventions. People and their family members were involved in care planning decisions.

Is the service well-led?

Requires Improvement 

The service was not always well led.

At the last inspection this home was rated as 'requires improvement' in this area, because systems of audit were not effective and actions were not always taken. The manager had made improvements to the providers systems which still needed improvement to ensure they were effective and supported good care outcomes. Where checks were delegated to others, there needed to be greater scrutiny actions were taken to improve the delivery of service. The service did not have a registered manager in post at the time of our inspection visit.

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 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 visit took place on 13 December 2017 and was unannounced, and consisted of three inspectors. Two inspectors returned announced on 18 December 2017.

We reviewed the information we held about the service. Prior to this inspection, we received information that suggested the management and governance of the home was not sufficient to address people's concerns. We looked at these concerns as part of this inspection. We also looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. We looked at the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information when conducting our inspection, and found it reflected what we saw during our inspection visit.

To help us understand people's experiences of the service, we spent time during the inspection visit observing and talking with people in the communal areas of the home, or their bedrooms with their permission. This was to see how people spent their time, how staff involved them in how they spent their time, how staff provided their care and what they personally thought about the service they received.

We spoke with nine people who lived at Park View and four visiting relatives. We spoke with a regional operations director, a dementia service manager, a manager (who has applied to become the registered manager) and a deputy manager. We spoke with three care team leaders, four care staff, an activity co-ordinator and a housekeeper (in the report we refer to these as staff). We also spoke with four visiting

healthcare professionals.

We looked at seven people's care records and other records relevant to their support, such as medicines records and daily records. We looked at quality assurance checks, audits, people and relative meeting minutes, compliments, complaint records, training records, medicines, nutritional charts and incident and accident records. This was to see whether the care people received was recorded and delivered according to people's care plans.

Requires Improvement

Is the service safe?

Our findings

People were safe and protected from abuse or poor practice. People told us they felt safe at the home, because they felt safe with the staff who supported them. One person told us they felt safe because it was quiet at night and staff always came quickly when they rang their call bell. A relative told us they were confident their relative was safe at the home, which enabled them to relax and enjoy their relation's company when they visited them.

The provider's policies for safeguarding and whistleblowing were clearly displayed in the main office and in the care team managers' offices, to ensure staff were constantly reminded of them.
Staff had received training so they understood what might constitute abuse and the action they should take to safeguard people if they had any concerns. One staff member commented: "It is not all about physical abuse, it could be the way you talk to a person. I would report it to the care team manager (CTM) or to the management." Staff told us they would not hesitate to report poor practice by another staff member, such as not using the correct equipment to support people safely, "I would report it straightaway and [Manager] has an open door policy or you could whistleblow."

There were enough staff to meet people's needs, although the staff team did not always consist of permanent staff which people felt did limit some staff's knowledge of their routines. People who spent time in their own bedrooms all had a call-bell within reach. They mostly thought there were enough staff, because staff came quickly when they rang the bell. We saw staff responded to the call bells promptly. One person expressed the view that it would be better to have more staff on duty in the morning as some other people became agitated if they had to wait to be supported. They told us the domestic staff supported people with breakfast, but only for the first hour. The person explained, if people chose to get up after nine o clock, then care staff had to organise their breakfasts, which took them away from supporting other people to get washed and dressed. We discussed this with the manager and regional operations director who agreed to look at how staff were deployed to limit potential concerns.

To help recruit permanent staff, the provider was supporting the manger to recruit suitably skilled staff to fill vacant positions so they had a consistent and permanent staff team. Head office staff were undertaking pre-interview telephone calls to applicants to ensure only suitable applicants were invited to interviews. In the meantime, the staff team was supported by high agency use, on average between 300 and 350 hours a week. On top of these hours there was a high dependency on temporary staff from another home within the provider group. The deputy manager told us they tried to ensure consistency of care by using the same agency staff. "The agency staff are very familiar with the home, the residents and the staff."

Staff felt staffing levels on each shift enabled them to support people safely. "We have occasional days when people are off sick but they are not too bad." "Staffing levels can be good, but they can be low if people phone in sick." Staff told us that staffing levels were improving. For example, one staff member told us that staffing levels on the ground floor had been increased from two care assistants to three care assistants and a CTM. One staff member told us, "It has got better in the last couple of months. We seem to have more staff members." The provider used risk assessments in each person's care plan to calculate the dependency

levels in the home and how many staff were needed to respond to people's needs safely and effectively. However, the dependency tool did not take into account the layout of the home and their current reliance on agency staff. The manager agreed to review their dependencies with this in mind to give them the confidence, staffing levels continued to remain sufficient.

People's care plans were regularly reviewed and their risk assessment scores were updated when their needs and abilities changed. Staff used body maps to show when people had marks or bruising to their skin. One person's risk assessment showed they were at risk of falls. The guidance for staff said the person should have a call bell within easy reach and a sensor mat beside their bed, to make sure staff knew if the person tried to get out of bed unaided. We saw the call bell and sensor mat were in place as described in their care plan. Their risk assessment had identified that bed rails should not be used, as they would present a greater risk if the person did try to get out of bed independently.

Staff understood the risks and reasons when people displayed behaviour that challenged others so adopted appropriate strategies to support them. We saw staff responded to one person's regular calls for help with smiles and reassuring words and voices. We saw staff supported another person with kindness when the person was agitated and started shouting. However, other risks were not always mitigated fully. We looked at risk assessments for a person who smoked. There was a risk assessment in place which stated that a member of staff must accompany them outside to smoke and they must never be left unattended. During our visit, staff were with the person and staff noticed this person had some burn marks to their trousers. The risks around this had not been recognised by staff to consider whether the person needed some extra risk management plans in place to keep them safe. For example, the use of a fire retardant apron. The manager agreed to look into this and put safety measures in place.

People received their medicines as prescribed, from trained and competent staff. One person told us they usually received their medicines at the same time every day and staff explained what each medicine was for. People told us staff helped them to manage any pain so they were not in discomfort. "When they are doing the pills, they always ask if you want pain killers." Medicines were checked and administered as prescribed. Medicines were stored in line with manufacturer's guidelines and time critical medicines where given when we required. Medicine Administration Records (MAR) were completed correctly and daily checks and stock counts kept errors to a minimum. Guidance was in place for people who needed 'as and when required' medicines, such as pain relief so staff gave these medicines consistently and safely. Body maps were not always completed to show staff where topical creams should be applied and it was not clear how often they should be applied. MARs for creams recorded 'Apply as directed'. Speaking with staff, they gave a different account to where and when to apply creams. The manager agreed to discuss this with the pharmacy so staff were consistent in where creams needed to be applied.

The home was clean and well-maintained. A visiting healthcare professional confirmed the home was always clean and tidy, as were the people living there. One person who chose to spend their day in their bedroom said, "They come in every day and clean." A domestic staff member told us they had received training to support their understanding of their responsibilities around infection control. They said they had all the equipment they needed to clean the home in accordance with good infection control practice.

Maintenance and safety checks had been completed. These included safety checks of utilities and water safety. Records confirmed these checks were up to date. In addition, there was an up to date fire risk assessment and regular testing of fire safety and fire alarms so people and staff knew what to do in the event of a fire. People who used the service had Personal Emergency Evacuation Plans (PEEPs) which would provide emergency personnel with vital information about people's mobility needs in case of emergency.

Staff reported incidents and accidents and these were analysed monthly by the manager to prevent re-occurrence. The manager told us they looked at the fall, the number, the location and injuries and took necessary action, such as referral to the GP. The manager said they analysed complaints, people's weights, and call alarm bell times (call durations). They said they were confident lessons learned limited potential for similar issues. However, we looked at one person's care plan and saw that on 10 December 2017 the person had fallen out of bed and was found on the floor between the wall and the bed. When we visited on 13 December 2017 we saw there was still a significant gap between the wall and the bed. We could not be sure the risk had been properly assessed and consideration given to moving the bed to reduce the risks to this person. The manager assured us action would be taken to prevent the potential risk of falling.

Good

Is the service effective?

Our findings

At the last inspection visit we rated this area as requires improvement. This was because food and fluid charts failed to accurately record what people had consumed. We found one record said a person had a full meal and dessert, when they had not eaten anything. We also found action was not always taken swiftly for those people identified at risk of dehydration or malnutrition. At this inspection, we found improvements had been made although further checks would ensure staff remained consistent in their recording.

Some people were at risk of not eating and drinking enough and food and fluid charts were used to record their intake. This meant staff could quickly identify when people needed to be encouraged to drink or eat more. Regular monitoring of people's weight was made and where individual concerns were identified; dietician support was sought and followed. However, we still found inconsistencies in some records although this had improved. Some records were totalled and reflected what people had, others were not totalled and portion sizes were not always recorded. This meant it was difficult to establish if people's intake was monitored correctly and how this may affect weight loss or gain. The manager assured us they would increase checks to ensure records accurately recorded people's consumption so action could be taken where necessary.

People's needs were assessed before they moved to the home. A dependency score was used as part of the assessment to identify the person's level of needs, and the staffing required to support them effectively. The manager was confident when people came to live at the home, they had enough and suitably trained staff to provide people's care. Care plans included risk assessments using recognised risk management tools, such as Waterlow assessments for risks to skin and Barthel dependency assessments. People's care plans included an assessment of their needs and abilities and guidance for staff to support the person to achieve good outcomes.

Staff told us the induction programme and training provided helped them to effectively meet people's needs. We spoke with a recently recruited staff member. They told us they had an induction which included all essential training and working alongside more experienced staff so they could understand people's needs. This was the staff member's first job in care and we asked whether the induction gave them the confidence to fulfil their role. They responded, "It was still a learning curve, but I was starting to get my confidence." Staff told us they received training through e-learning and face to face. Training included fire safety, moving and handling and infection control. We saw staff effectively implementing their training in helping people to mobilise safely. We saw two staff helping a person to transfer from their chair to a wheelchair. They did not rush the person, but gently offered encouragement and reassurance. They ensured the brakes on the wheelchair were on and put the footplates in place before they moved the person. A healthcare professional commented that the needs of people living in the home had increased but said, "They cope with it well. If they are not sure, they will ask. They have been quite quick to identify when they are struggling."

We were told that all staff received the same training including dementia awareness because they were constantly interacting with people living with dementia. Some staff had received extra training and were

dementia champions. "I help guide staff who are new to speak with the residents and encourage them to come up with new ideas." Some people could display challenging behaviours associated with their diagnosis of dementia. Staff had received training to help them support people who could become anxious or agitated. One staff member said this training gave them more confidence, particularly when supporting one person who showed aggression. Staff told us they were supported to gain external qualifications in health and social care.

Staff said they received supervision meetings. Staff told us they felt the meetings were positive because it gave them an opportunity to discuss the areas they would like to develop. "You set yourself targets and at the next meeting you see if you have achieved them." One staff member told us they had asked for training in continence and catheter care at their last supervision meeting and this was being looked into.

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 to 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 are called the Deprivation of Liberty Safeguards (DoLS). Where restrictions on people's liberty had been identified, the appropriate applications had been submitted to the authorising authority. For people whose behaviours changed and posed a greater risk to their safety, urgent DoLS applications were submitted.

Staff worked within the principles of the MCA. People told us staff asked for consent before providing care and respected the decisions they made. For example, one person told us it was their personal choice to spend most of their time in their bedroom and have their meals there. Staff respected their choice. This person also said they chose to only have one of their prescribed creams applied once a day instead of twice a day. This person had capacity to make that decision and staff respected it. A staff member explained, "We can't physically force people to do something if they don't want to. If they refuse we report it to the CTM and log it." There was evidence in people's daily records of staff respecting people's decisions when they declined support, but recording this in their care plans. One healthcare professional told us, "The residents seem to be very much in control of those parts of their lives they can be in control of."

People's care plans included the RESPECT form, as agreed with the local clinical commissioning group. The RESPECT form confirmed that the person or their representative had been consulted about their wishes in the event of the person going into cardiac arrest. One care plan we looked at stated the person's wish to receive cardio pulmonary resuscitation was known and would be respected if the need arose. For another person, who did not have capacity to understand the risks, a qualified healthcare professional had made a decision in the person's best interests.

People told us they had a choice of meals and could eat in the dining room or their own bedroom, according to their preference. One person said, "The food is always good, always hot and we always have a choice." At lunch time, we saw the care team manager took control of the lunchtime to make sure everyone was offered a choice, was served a hot meal and people received the assistance they needed. Menus in the dining room included pictures to assist people to make a choice about their meal. We saw staff showed people sample meals on small plates which enabled them to see and smell the food before they made an informed choice. Staff took the sample meals to each person who ate in their own room, which meant they were offered the same choice and respect. People chose which table to sit at, which meant they were able to sit in friendship groups. There was quiet music playing in the background and the meal was not rushed. People were offered a hot drink at the end of the meal, which encouraged them to sit still and digest their

meal over a conversation.

People were supported by other health care professionals to maintain their health. Records showed people were supported to attend regular appointments with healthcare professionals, such as opticians, consultant psychiatrist, physiotherapist, SALT and a dentist. The deputy manager explained that a new system had been introduced whereby an advanced nurse visited the home regularly with a named GP, which had improved outcomes for people. "Continuity of care to the residents has improved greatly. The same GP is seeing people so they can see the improvement or deterioration. There is familiarity with the patients and relatives and it has actually reduced the impact on GP time." Healthcare professionals confirmed staff were effective at following their clinical advice. One said that the handover of information could be more difficult with agency staff, but a communication book had now been introduced on each floor so nothing was missed.

The premises had been purpose built and were decorated to support people to move easily from their own bedroom and around the communal areas of the home. There were several rooms and areas along each corridor where people could sit and read, rest or watch what was going on around them. One person told us they liked to sit in one of these spaces along the corridor and 'watch the world go by'. Some people had their name and a picture on their own bedroom door, to enable them to find their room more easily. The directional signs were in large print and included pictures to help people understand the words. We saw this was effective as some people made their own way to the dining room at lunch time.

Good

Is the service caring?

Our findings

Everyone we spoke with told us staff were kind, polite and respectful of their wishes. A relative told us their relation was as happy as they could be anywhere, because they liked their room and they liked the staff. They said, "The staff are fantastic with [Name]. They are all lovely." The provider displayed the names and photos of all the staff who worked at the home, to support people and relatives to understand staff's responsibilities.

People spoke positively about the friendliness and willingness of staff. They told us they enjoyed their company. Comments included: "It is very good, they look after you. Staff are good, I can joke with them" and "It is just like home, in fact it is better than home." Staff told us they enjoyed working in the home and being with the people they cared for "The atmosphere is always nice and everybody is always smiling and polite." "I love it. I love giving good care and making sure people are empowered and have their needs met." Healthcare professionals commented on the caring nature of the staff at Park View. Comments included: "Overall the staff are really caring, that is the thing that strikes me. They are always concerned." "It is definitely a caring environment, the carers (staff) are genuinely interested in people" and "The carers (staff) know the clients well, their idiosyncrasies and what matters to them."

One staff member described how it was important to ensure people had the 'little things' that were so important to them. For example, they described how they always helped one person to put their makeup and favourite perfume on. "I think it helps them keep their identity. It is also giving them their independence as well. As soon as you put that on, something that is important to them, you are giving them their identity."

Staff took time to be with people. They engaged and interacted with people as they went about their tasks. They sat with people when writing up daily records and took the opportunity to chat with people. One person told us how staff accommodated their wishes. They told us that sometimes they really fancied a Chinese meal and staff would arrange for it to be delivered for them. We asked why they didn't ask the cook to prepare Chinese for them and they said, "It wouldn't be the same as the Chinese doing it."

Staff gave people reassurance. One person was very anxious and had some insight into their memory loss. We saw staff gave them regular physical and verbal reassurance. The person had a laminated note on their walking trolley reminding them where they were and that they were being looked after. A staff member explained, "The sign gives her some reassurance. She needs to know her needs are being met and that she is not alone. It is important that when she is in that moment (of anxiety), she feels that she is not on her own." One person liked to draw and said, "They (staff) bring their kids in so I can teach them how to draw." This gave the person a sense of value and involvement in the wider community of the home. One healthcare professional said that staff respected people's diversity and said, "I would place the people I love in here."

People who had the capacity to discuss and agree how they were cared for and supported had signed their care plan, which demonstrated their involvement and agreement in how their care was planned and delivered. One person told us they had chosen the curtains and matching bedspread in their bedroom when the home had been refurbished.

People told us they were supported to maintain their independence and staff only assisted them if they wanted assistance. One person told us they were pleased they could help themselves to milk for their cereals when they were ready, because it was important that the cereal did not go soggy before they ate it. A relative told us their staff respected their relation's decision to 'not get out of bed', but staff were able to persuade them that it was good for their self-respect and independence.

The provider understood the importance of promoting dignity and respect in care. They had identified a member of staff as 'star of the month' for dignity. The 'star' staff of the month had their photo displayed on a certificate in reception to encourage staff to note and follow their example in supporting people. People told us staff respected their privacy. One person told us staff always asked if it would be alright to clean their bedroom.

One person told us they were supported by an advocate to manage their financial affairs. The provider promoted the services of advocates by making information about advocacy services available in the reception area.

The 'tea-room' on the ground floor was open to people and visitors to help themselves to drinks and snacks. The furniture was arranged into several smaller spaces which gave more privacy for people to entertain their visitors. A relative told us they had enjoyed playing dominoes in reception with their relation and a friend. They told us as they always felt welcomed at the home.

Good

Is the service responsive?

Our findings

People said staff were responsive to their needs. A relative told us staff understood people well and responded to them as individuals. They told us staff encouraged people to, "Laugh and joke and have a bit of banter."

People's care plans included a brief life history, which included information about the person's work and home life, their important relationships and any expressed likes and dislikes. This enabled staff to get to know people well and to understand what was important to them. Where they were able, people told us they were involved in making decisions about their care and their preferences for how it was delivered. "Every so often they come in, sit down and we have a talk."

People's care plans contained information about what was important to them. For example, in one person's care plan it stated that it was important to them to spend time in the garden and to be given the opportunity to read the daily newspapers. Another person's care plan clearly stated their preferences at night. It informed staff the person liked their curtains closed, a low light and their door slightly open. We asked staff why it was important to know about people, their backgrounds and what was important to them: "It affects the way they behave and if you understand that, it can make their day better. If they are upset you can distract them by talking about what is important to them." Another said, "There may be something in their background that will help us give the right support to them living here."

Care plans contained a lot of information built up over a period of time. We were concerned, given high agency use that new or agency staff may not have the information they needed at a glance and discussed this with the manager. At our second visit we saw the manager had introduced a 'snapshot' of people's needs in their rooms. This gave staff an overview of what support the person needed and what was important to them. Staff spoke positively about this: "They are really helpful, especially for agency staff." People's care plans were regularly reviewed and were updated when their needs and abilities changed. One person's care plan showed that after a period in hospital they had become more dependent. Their dependency score had increased, because they needed more support from staff than they had needed before they spent time in hospital.

People's communication needs were assessed and guidance for staff explained how they should support the person to understand information. One person's care plan identified the person had some loss of hearing, but declined to wear a hearing aid. The instructions for staff were to, "Speak loudly and clearly, while facing [Name] and repeat if necessary." We saw staff followed the guidance when they supported the person, by looking directly at the person when they spoke with them.

People told us they spent their day in their preferred way. One person told us they liked to stay in their room, but went to the dining room for lunch to stretch their legs and for a change of scene. They said they preferred their own company and did not want to join in with the activities. One person told us, "Staff are very good at trying to fit in with what individuals want and prefer. They stress this is 'our home'." There was a list of the activities and events on offer outside the tea room, so people and relatives could plan which

activities and events they would like to attend. The number of puzzles, board games and art and craft work available for use in two rooms in the home meant people could use these whenever they wanted to.

On the first day of our visit, people told us they enjoyed the concert that some visiting singers had put on. They told us they had enjoyed a pantomime that had been put on by an external group of actors earlier in the week. One person told us they used to attend a fortnightly exercise class. They told us the trainer was really helpful and had given them ideas to keep fit and active in the privacy of their own bedroom. There was a raffle in reception which included prizes that had been donated by the kitchen staff. The prizes were presented in baskets and wrapped in a way that would appeal to people.

There was a post box in reception for people to post their season's greetings cards, to maintain their links with the community. A relative told us they were encouraged to join their relation in the shared activity sessions at the home.

People knew how and who to make a complaint to. People told us they would feel happy to raise any concerns or complaints – "I would tell one of the girls (staff) and she would call the boss. But, touch wood, I haven't had anything to complain about." One staff member explained how they would support a person if they wanted to complain, "I would go through the channels and make them feel that if that is what they wanted to do, it is the right thing to do." A relative told us they would not hesitate to complain to the manager, if they needed to. They told us they had a good relationship with staff and any concerns raised had been resolved promptly and without detriment to their relationship with staff. We looked at the complaints register and found six complaints had been received in 2017. All of these complaints had been dealt with and if action could be taken to prevent similar issues, this was taken.

No one at the time of our inspection visit received end of life care. The service provided end of life care for those people whose preference it was to stay in the home. Staff had not received specific training in end of life care, but understood the importance of knowing the person and how they wanted to be cared for. One staff member told us it was most important to, "Spend time with them, make them comfortable and keep their dignity." This staff member went on to say, "I have even come back in my own time and sat with people. They become your family." Some people had shared their wishes about their end of life care and this was recorded in their care plan.

A healthcare professional told us that a recent death in the home had been handled with great care and compassion. They explained the service had worked with the GP and the nurses to ensure all the anticipatory medicines were in place to ensure the person remained pain free – "The end of life care was great. They (staff) were really kind. The family were very happy with the care he received here. It was very well managed." They said staff were receptive to looking at ways to ensure people remained in their home. We saw that several of the compliments the home had received related to the care their family members had received at the end of their life. One compliment card read, "At the end of her life she was surrounded by so much care and love."

Requires Improvement

Is the service well-led?

Our findings

People were happy living at Park View. We asked one person if they would recommend the home and they replied, "Yes because they look after you." A healthcare professional told us, "I like the approachability of the staff and their attention to detail and their ability to cope with complex and difficult issues."

At the last inspection this area was rated Requires Improvement because we found a lack of managerial oversight by the provider and management. Audit systems were not effective to drive improvements within the service. We found monitoring of people's food and fluid intake was not always consistent with what they had consumed. Actions were not always recorded to show how people were supported and completed audits had not identified this as a concern. At this inspection, we found some improvements had been made but improvements were still needed. We found when some checks and tasks were delegated to others, there was no effective process to ensure actions had resulted in improvements.

For example, one area of concern was a lack of monitoring of weight loss in the home at service level. The provider's individual weight records for June and July 2017 recorded seven people as losing weight. However, in August, 23 people lost weight and in September, 20 people lost weight. No evidence of any consideration was given as to whether this was due to a menu change, hot weather or inaccurate recording. Our own checks of food and fluid records continued to show inconsistencies in the level of detail provided. It was the responsibility for CTMs (care team manager) to check daily, yet this was not done and no one checked to ensure CTMs completed their checks. (CTMs are senior staff responsible for leading the shift and completing regular checks and care plan reviews). This meant the records that supported people's intake could not be relied upon to provide an accurate picture of what people had consumed and any potential cause for concern.

Other records continued to record checks as accurate when they were not. It is important that pressure relieving equipment is regularly checked to ensure it is being used effectively. For example, pressure relieving mattresses should be on the correct setting to support the person's weight to reduce the risks of skin damage. We checked four people's pressure relieving mattresses. Three were on the correct setting for the person's weight. The other was set at 32kg but records showed the person weighed 59.4kg on 20 November 2017, three weeks prior to our visit. On the day of our visit the mattress had been checked at 2.00pm and signed to confirm it was set at the correct weight when it was not.

Care plan records were reviewed however, we saw one care plan where there was a body map which indicated the person had very sore skin which was at risk of breakdown. The person's care plan had not been updated to reflect this change and did not record they were now cared for on an airflow mattress. We raised these issues with the manager who agreed to take immediate action, however staff knew the level of care needed. The manager assured us they would themselves take more of an active role in checking senior staff when checks were delegated to them, so they could be confident action was taken when needed.

Prior to this inspection, we received information from the public and local authority about the lack of management oversight from the provider, in particular how management instability affected the delivery of

service. Since the last inspection in November 2016 there had been a change of registered manager. The registered manager left the service in July 2017. A temporary manager was appointed, then left to manage another service in October/November 2017 before moving back to manage this service again from December 2017. A requirement of the service's registration is that they have a registered manager. The manager told us they had applied to be the registered manager at this location. The regional operations director explained the reasons behind the recent management changes and was confident, the manager applying for registration with us, was 'right for Park View'.

During this inspection we found some people and staff did not know who the manager of the home was. One person told us, "They have just changed over and I don't know who it is now." A staff member told us, "I think Sheila is coming back." Another said, "Geraldine is temporary I think. Sometimes it is confusing because each manager changes things." The manager agreed this would be addressed with people and staff imminently so they knew who was in charge. A relative told us their relation had continued to receive good quality care from staff, despite the changes at management level. They said, "Everyone is so warm and friendly, it's so welcoming." They told us they hoped the current manager would stay, because they had had time to get to know and trust them.

Changes in management meant some people, staff and healthcare professionals lacked confidence because they experienced inconsistencies in the delivery of care and communication. One complaint we saw from a relative praised staff but focussed on the provider's lack of oversight and responsibility to strengthen management processes while periods of instability were experienced. This was supported by others. One healthcare professional said, "My issue is more the management structure." Another felt a permanent registered manager would provide consistent leadership for the benefit of the home. They described the current manager as 'proactive' and went on to say, "She is very good, but still only temporary. I think what they need here is permanent good leadership." This healthcare professional spoke particularly positively about the deputy manager as the consistent member of the management team – "The deputy manager is excellent. She knows the residents really well and she is very motivated." This was demonstrated during our initial conversations with the deputy manager when we arrived for our visit. They had a good understanding of the needs of each person living in the home.

Staff spoke positively about the new manager, "[manager] has done a lot for this home. She has done a lot for the staff and the residents. She has got the ball rolling for my NVQ which I've been asking to do for a while now." "If I had any concerns, I would go to the manager or deputy manager." Staff particularly spoke of the consistent support of the deputy manager during the periods of managerial change.

The manager explained to us what they had prioritised and what their challenges were since they came to the service. They were pleased with the staff team but wanted to increase the permanent staff numbers so to reduce reliance on agency staff. They believed staff provided a good quality of care but wanted to improve the managerial oversight and stability for people and staff. They recognised constant changes made it difficult for people to have confidence actions would be taken and sustained.

Recruitment and retention of permanent staff remained an on-going challenge. The deputy manager explained that a lot of time was wasted because people would apply for positions, but would then not turn up for interview. The provider was looking at ways to streamline the recruitment process including their HR department conducting initial interviews over the telephone.

There was a system of checks and audits. For example infection control weights, accidents and incidents, equipment, water quality, and health and safety. Action plans from each individual audit was compiled into a service improvement plan. The regional operations director visited and checked this action plan to ensure

improvements were made and that it was reviewed and updated monthly. We checked the latest action plan and found some actions had been addressed, although others remained open. The manager told us most of them had been actioned, but the action plan remained incomplete. The manager agreed to update their plan so they remained focussed on those improvements that still needed addressing.

Park View was working in partnership with other agencies, including a new project funded by the Oken charity. The aim of the project was to provide more proactive healthcare at Park View. The charity funds two advance nurses who are attached to three local GP practices who have patients living at Park View. Nurses visit the home twice weekly with a GP and review each person. They will also visit when a need is identified and provide advice. The nurses support staff so they do not need to call 999 or the GP surgery so often. The project promotes 'proactive' healthcare rather than reactive. It also aims to reduce the need for hospital admissions as any decline in health can be managed before it becomes acute. This project started at the end of May 2017 and the CCG are reviewing the information. The service had recently joined a hydration project, the aim of which was to encourage people to drink more which in turn would reduce the number of falls. This was a project being run by South Warwickshire Foundation Trust with an occupational therapist being the link with the home. Six or so people had been identified as being at risk of not drinking enough and their fluid intake was being closely monitored. A healthcare professional felt this was very positive.

However, we discussed with the manager the importance of sharing this information with staff. Our concern was that a senior member of staff on the second floor had not worked at the service since October 2017. They were not able to tell us about the hydration project, the purpose of it and they thought it had actually finished. "It may be because they used to get a lot of UTIs so it may be something to do with that. I think it has finished now." This meant there was no effective leadership for this project on that shift. This supported what healthcare professionals told us about a lack of communication sometimes because of changes in management.

The provider had displayed the rating on their website and the ratings poster was displayed in the communal entrance from our last inspection visit, which they have a legal duty to do. The registered manager completed a PIR which provided us with an accurate reflection of what the service did well, and where development was needed over the coming 12 months.