The Asian Health Agency

The Parvaaz Project

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Our inspection took place on 14 July 2017 and was announced.

The Parvaaz Project is a community-based service for people with a learning disability, situated in a residential part of Slough, Berkshire. The service provides multiple different types of support, including personal care, community transport and a day centre. Only personal care is regulated by law, and our inspection has included evidence about this and not other support offered by the service. The service provides care for children and younger adults. At the time of our inspection, about six people received personal care, although the service provided support to about 30 people and this was increasing.

The service must 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 2008 and associated Regulations about how the service is run.

At the time of our inspection there was a registered manager. However, this registered manager was not in post. The registered manager had not cancelled their registration with us when they left their position, and therefore we removed them from the register as part of our inspection. We could see from our records that the current manager at the time of our inspection was completing their application to register with us.

This is the first inspection of the service since they registrered with us.

People were protected against abuse or neglect. Staff attended regular training that ensured their knowledge of safeguarding people was up-to-date. People had personalised risk assessments tailored to their support requirements. We saw sufficient staff were deployed to provide people's support. We made recommendations about the employment application form and the service's medicines policy.

Staff received appropriate support from the service and management to ensure their knowledge, skills and experience were appropriate for their roles. The service was compliant with the provisions of the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. People had access and support to visit community healthcare professionals.

Staff at The Parvaaz Project were caring. The service had received many compliments about the care received, and relatives we surveyed felt staff were kind. People could not participate in care planning themselves, but staff worked with other healthcare professionals to ensure that support was suitable. The service had appropriately considered communication barriers and put strategies in place to ensure key messages were delivered to families who relied on the support from care workers.

People had detailed care plans which were regularly reviewed. We saw care plans contained detailed

information relevant to each person. The service had an appropriate complaints system in place.

The service was well-led. There was a positive workplace culture and staff felt that management listened to what they had to say. We saw there were a limited number of checks by the management and provider to measure the safety and quality of care. We made a recommendation about the use of an action plan or service improvement plan.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse and neglect.

People's support risks were assessed, mitigated and documented.

People had access to sufficient staff for their support needs.

Is the service effective?

Good

The service was effective.

People received care from staff with the right knowledge, skills and experience.

People were protected by the provisions of the Mental Capacity Act 2005.

People were supported with their access to community-based health and social care professionals.

Is the service caring?

Good

The service was caring.

People and relatives were involved in care planning and reviews, when possible.

The service used alternative methods of communication with people and families.

People's confidential personal information was protected.

Is the service responsive?

Good

The service was responsive.

People had person-centred care plans which were regularly reviewed.

People, relatives and others knew how to raise complaints if they had a concern.

Is the service well-led?

Good

The service was well-led.

There was a positive workplace environment for staff.

Staff enjoyed providing care and support to people.

Management took account of what staff had to say.

Some audits and checks on the quality of care were completed.

The Parvaaz Project

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection.

Our inspection took place on 14 July 2017 and was announced. We gave the service 48 hours' notice of our inspection because it is a small service and the managers were often out of the office supporting staff or providing care. We needed to be sure that they would be in.

The inspection was carried out by two adult social care inspectors. One inspector visited the service and the other inspector completed telephone interviews to obtain people's feedback about the service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we already held about the service. This included previous notifications we had received. A notification is information about important events which the service is required to send us by law. We checked information held at Companies House and the Information Commissioner's Office.

Prior to our inspection, we sent 39 surveys to people who used the service, relatives or friends of people, staff and community healthcare professionals. We received nine responses. At our inspection, we were unable to speak with any people who used the service or relatives. We spoke with the manager, the deputy manager and one care worker. After our inspection, we were able to speak with two relatives and one care worker by telephone.

We looked at four people's care records, three staff personnel files and other records about the safe management of the service.

Good

Is the service safe?

Our findings

People were protected from abuse and neglect. There was an appropriate safeguarding policy in place for staff to read. The policy covered the safety of both children and adults who used the service. The manager also told us there was access to contact information for the local authority, including who to contact after hours. Information about protecting people from abuse was contained within the staff handbook.

Staff received regular training about safeguarding. This commenced during their induction at the service and continued during their employment. We looked at training information and saw most staff had recent training about safeguarding. Twelve staff we surveyed prior to the inspection indicated they knew what to do if they felt abuse had occurred, and also recorded that they felt the service provided care free from abuse. The manager was not aware of the Berkshire safeguarding procedures, but they assured us they would access and read the document.
There was a satisfactory whistleblowing procedure. This was discussed with staff at regular intervals, such as staff meetings. The manager told us that staff were encouraged to approach themselves or the deputy manager, and could also contact the director if they wanted to reveal information about poor care of people by others. A care worker we spoke with was aware of whistleblowing. They told us "It's a massive part of keeping the person safe [and] also the staff member or colleague."

To ensure people's care was safe, appropriate risk assessments were in place. We saw that each person who was introduced to the service had a referral in place. This provided preliminary information about the person's health, care needs and the type of support required. The deputy manager or manager completed a pre-service visit to conduct an assessment of the person. Based on information from the visit with the person and relatives or others, a risk management plan was formulated prior to the person receiving support. Risk assessments we saw included moving and handling, eating and drinking, going into the community and those related to people's individual health conditions. We saw the risk assessments were updated regularly.

There was sufficient staff deployment to meet people's needs. The manager was clear that a person could not commence receiving care unless their needs could be managed and there were enough staff to cover requested support. They went on to explain two examples where the service refused care on the basis of safety. One was a request for support too early in the morning for the service to cover and the other was a person who needed many staff at once. The number of staff needed was determined using a calculation of people's needs, the ability to ensure safe care and the funding provided by commissioners to support people at the service. Demand for the service was growing, and the manager explained recruitment of more care workers was in progress. The manager told us they always had a 'forward view' of the rota, taking into account calendar events like Easter, Christmas, Ramadan and school holidays. They explained these were periods where families might increase requests for support and staff would also request leave. This was a good example of ensuring safe staff deployment at all times.

We looked at safe staff recruitment. We examined the content of three staff members that had recently commenced with the service. We saw appropriate checks of new workers was completed. This included

verification of new applicants' identities, checking previous criminal history via the Disclosure and Barring Service, obtaining proof of conduct from prior health and social care roles, and ensuring staff were healthy enough to perform their roles. Minor improvements were required. This included the space provided on the application form to record prior work history. We saw this was too small to record an applicant's full employment list if they had multiple roles in the past. We did note that some staff had no interview notes recorded in their file. The manager was aware and showed us that when they commenced in their role, they had implemented a system of recording all interviews. The lack of interview notes for some staff was a historical matter that was rectified.

We recommend that the service considers improvements in the employment application form to ensure all information about fit and proper persons is recorded.

No one who used the service at the time of our inspection received support with their medicines. However, we asked questions about the service's ability to support people with medicines. Staff received theoretical and practical training in how to manage people's medicines. This included a period of supervised practice and competency assessment before new staff were permitted to solely administer medicines. There was a medicines policy in place; however the content did not contain information about the procedure for reporting medicines incidents.

We recommend that the provider adopts national guidance and reviews their medicines policy to ensure they follow best practice.

Good

Is the service effective?

Our findings

Staff received good support to enable them to have up-to-date knowledge and skills in care practices. New staff who had never worked in adult social care were required to complete Skills for Care's 'care certificate'. The care certificate is a nationally recognised set of standards care staff are required to have. We saw evidence this was appropriately completed. New workers were assigned a buddy who they shadowed on shifts for up to two weeks, depending on their prior experience of personal care work. New staff commenced supporting people with less complex needs, and were trained over time to work with people who had more complex or challenging needs. A probation period of three months was in place, although this could be extended if the staff member needed further development of their skills and knowledge. Staff were required to undertake the training at set intervals and the manager monitored staff completion relates. Staff also had regular supervision and performance management meetings with the management, which included discussions about the workers' abilities. Spot checks of workers in the community were done by the management. This was to ensure that people who used the service received effective care.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Twelve staff we surveyed prior to our inspection confirmed they had received training in and understood their responsibilities under the MCA. Two community healthcare professionals that responded also felt the staff and management of the service understood and correctly applied the requirements of the MCA.

Most people who used the service did not have the ability to consent to care or make other decisions for themselves. The service ensured they had all of the necessary information about people's mental capacity in order to provide the right care. A personal needs questionnaire was often sent to the service from the local authority team for people with learning disabilities. This contained extensive information about a person's mental capacity and the ability to provide consent. This was under a section called 'making decisions and organising my life.' The service used the information to help formulate people's care plans.

The service was informed about any other person who could legally provide consent on behalf of people. This was often after the Court of Protection had appointed a relative or the local authority as a deputy for the person. In the absence of a court-appointed deputy, the service correctly used best interest decisions. This mainly involved a person's relatives. Where appropriate community healthcare professionals were also included in the decision-making processes. Staff received appropriate training in the MCA and the management team ensured compliance with the legislation and associated codes of practice.

At the time of our inspection, none of the people who used the service received support with eating or drinking. The manager told is that staff often accompanied people to fast food establishments, cafes and restaurants. People were free to choose their own food and drinks based on their preferences, and staff would accompany the person in a social context as part of their care package.

Some people who used the service were independent, but relied on staff for additional assistance to access community healthcare professionals. The manager explained that care workers mostly accompanied people to visits with their GPs. This was often undertaken in a supportive role so that a person was not alone and helped alleviate any anxiety the person felt. Other health or social care professionals were sporadically involved in people's care. For example, people might see their social worker, psychologist or specialist nurse annually for reviews or check-ups.

In our pre-inspection survey, we received positive feedback from a community healthcare professional about the service. The respondent wrote, "As a professional working in a multi-disciplinary team, [we] have sat in multi-disciplinary meetings where the named service has been represented as a provider of services for the service user. [We] have noted compassion, a commitment and willingness of management of the named service to create innovative ways of working with the service-user and their family in a responsive and person-centred way which is highly commendable." This demonstrated the service worked well with other professionals to ensure people received effective care.

Good

Is the service caring?

Our findings

Most people who used the service were unable to participate in care planning or care reviews. We saw these often involved relatives or other family members making the best possible choices for people. The service recognised that many people's relatives could not read or speak fluent English. The manager explained this presented a challenge when care planning was completed for people who used the service. The manager also explained that the service had found some relatives did not have e-mail accounts or did not respond to letters that were sent to them about people's care. The service recognised there was a difficulty in communicating with others when organising care.

The manager explained the service's success with using alternative systems to help plan and review people's care. In addition to telephone calls, the service used text messaging as another method of communicating important information, confirming appointments or altering care packages. As the service had some staff who could communicate in other languages, they were able to send the messages by asking the staff member to translate. We were told that messages to relatives and family were often sent in Punjabi, Urdu and Hindi. The service found that by communicating with relatives and family members in languages other than English (where necessary), the information was most often accurately received and understood. This ensured people's care was not disrupted by language barriers.

The manager explained that families were able to contact themselves or the deputy manager directly at any time to discuss the care plan or package. On occasions, this included when the person who used the service had an increased need for support. We were told the management team would act as an advocate for the person and family, by communicating with local authority social workers and staff that funded the care. The manager stated that when a family had requested additional support and the commissioner was unable to support extra hours, they would escalate the request on behalf of the family. We were told the management team at The Parvaaz Project were often able to demonstrate people's increasing needs or requirements for care. This practice fostered good relationships with the commissioners which meant people's needs were met.

People who used the service were represented in the community, so their experience of life could be improved. The manager told us that staff attended certain forums to 'speak up' for people who used the service. For example, meetings they attended included those concerned with learning disabilities or mental health issues. We were told this networking benefitted people who used the service because it occasionally led to adjustments to a person's home or assisted in access to suitable holidays and social events.

We observed staff had a good professional relationship with the people they supported. Staff were able to easily tell us about people's personalities and preferences, what care they required and what they liked to do. We saw staff were kind, patient and attentive with people. Staff facilitated a relaxed environment at the service, and we saw they laughed and joked with the people they supported.

People who used the service were unable to express their views. However staff were aware of people's likes and dislikes and always took this into consideration when they planned and provided support. People had

access to an advocate if they needed one or the family requested this. An advocate is someone who acts impartially on behalf of someone else when they cannot make decisions for themselves. People's social workers also checked the service regularly to ensure people's support was caring.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. This meant the service ensured that confidential personal information was handled with sensitivity and complied with the legislation.

Good

Is the service responsive?

Our findings

We looked at the care records for four people who used the service. We found people's care documentation was person-centred and not task-focussed. Each person had an individual support plan that contained personal details and background, their medical history and a range of documents that specified different aspects of care and support needs. Daily records were also recorded. We noted information about people was obtained from a variety of sources, so the service had the most accurate details for care planning. The manager told us that where possible, the person would be included but most often the service needed to seek information from the family. In addition, to prepare relevant care plans the service liaised with community healthcare professionals and school teachers.

We were told of examples of very responsive care by staff. A person who used the service demonstrated they did not like changes in their routines or new staff they were unfamiliar with. The manager explained this triggered inappropriate changes in the person's behaviour. The person's care plan was created to include this specific information so that staff cared for the person were aware of what the person disliked. Another example of this was that a person would only go into the community once they had eaten a burger in the day centre first. Staff were aware of this and ensured the care was carried out in the way the person desired. Other examples of responsive care included the ability to offer gender-specific care (male or female care workers) and respect religious and cultural values with any support provided. The manager said that if the service could not accommodate a person's or family's specific request, they would be contacted to discuss what alternatives might be available.

We were told a single central planning diary was used in the office to record specific events for each person who used the service. The planner included events in the future so that staff were aware of any particular special needs or requests. This was used in line with a secure, online calendar so that social activities, care reviews and other events were clearly recorded. When people needed specific appointments, staff could look at the care planning systems to find available slots to use for bookings.

Compliments, concerns and complaints were satisfactorily managed by the service. The service received many written compliments. The Provider Information Return (PIR) recorded that in a one year period prior leading up to our inspection, 13 compliments were received and recorded. The staff and management were aware of how to deal with complaints. There was an appropriate complaints policy in place. In addition, the staff handbook explained how to receive, report and submit any concern or complaint to the service's management. We looked at how the service dealt with three complaints they had received prior to our inspection. These were all appropriately investigated and all of the communication and documentation between the service and the complainants was stored on file. The outcomes of each complaint were clearly recorded.

We saw the service user handbook also contained information for people and their families about how to make a complaint. No surveys were completed about people's satisfaction with the service. This was difficult because most people would not be able to answer questions about personal care they received. The manager explained that a survey of families and relatives was underway, but this was not complete and

so the results were unavailable at the time of our inspection.

Good

Is the service well-led?

Our findings

The management of the staff engaged with the staff on a regular basis to communicate important information and build a positive workplace culture. We could see that staff we surveyed prior to our inspection felt the service was a good place to work. Of the twelve staff that responded to our survey, 92% indicated that their managers asked what they thought about the service and took their views into account. Staff meetings were held every month and we reviewed a series of the meeting minutes. The staff meetings were used for discussion about people's support and care, the performance of the service, and staff issues. There was also a suggestion box in the office where staff, and others, could provide feedback or ideas. They could submit the idea or feedback anonymously if they wanted to.

We also e-mailed all staff as part of our inspection to request any feedback about the service. Four staff responded to our request for feedback. One staff member replied, "My manager and deputy manager are both approachable if I need anything or need to talk. Both my manager and deputy manager communicate with each other and with myself and the other staff members. I feel that The Parvaaz Project provides a safe environment and service in which the staff and the clients are able use and able to adapt to different clients needs and disabilities. All the clients have care plans in which I am able to read up in my spare time, especially if their risk assessment has changed and if we are unsure. We have regular supervision meetings with either the manager or deputy manager or both. In these meetings, we are able to say what we feel about work and if we have any queries and what I say is always taken on board." Another staff member responded, "I have been working for The Parvaaz Project for [many] years now. I have no issues with the organisation. I am happy working here. I don't seem to recognise or see any problems about the quality and safety of the service we are providing...as all staff are well aware and trained to go by the client's care plan." A further staff member wrote, "I feel that management lead by example and through many years...in other companies, I can see why they have been given these roles. Both managers are dedicated to the work they do."

Accidents and incidents were always reported by staff and investigated by management. We saw records were kept of any incidents or accidents. Reports were made of minor incidents such as cuts, bruises and more serious events like behaviour by a person that placed them at risk. This enabled the management to ensure that actions could be put in place, where needed, to prevent the same incident from recurring.

A small number of checks and audits were completed to ensure the safety of care and quality of the service. This included visits from the provider's nominated individual. The visit report was not available at our inspection, but this was sent to us afterwards. We looked at the information from the May 2017 visit. This included a number of minor requirements for improving the service. Examples of entries in the report included two staff failing to wear their ID badge, personal protective equipment kits needed to be ordered and the office required some redecoration. The audit by the nominated individual also highlighted areas where the service was performing properly. These included checks of the finances, staff personnel files, and the management of incidents and accident reports. At out inspection, we asked if the service used any action plans, improvement plans or risk registers. The manager told us they did not use these types of documents.

We recommend that the service uses an appropriate system to record actions required when they are identified in audits or checks.

The service is required to have a statement of purpose. A statement of purpose documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. We found the statement of purpose for the service was appropriate, although not up-to-date. We were advised that the provider's office address was incorrect and not the one recorded on our register. We advised the registered manager of the process to amend the provider's address and they assured us they would do this after the inspection. We received the notification to change the provider's address a few days after the inspection.