Pathways Care Group Limited

Parkdale

Inspection report

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Colchester
Essex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Parkdale is a care home that provides accommodation and personal care for up to six people who have a learning disability and may have a physical and/or a sensory disability. There were six people in the service when we inspected on 3 May 2016. This was an unannounced inspection.

There was a registered manager in post. 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.

People were involved in decisions about how they were supported outside of the service. However, the provider's guidelines relating to the Deprivation of Liberty Safeguards (DoLS) were out of date. Without up-to-date policies and guidance from the provider, the management and staff at the service could not be sure that they were making appropriate decisions to ensure relevant safeguards were in place to protect people who may be deprived of their liberty.

People received care that was personalised to them and met their needs and wishes. Staff listened to people and acted on what they said. The atmosphere in the service was relaxed and welcoming. Feedback from people about the staff and management was positive.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Staff knew how to minimise risks and provide people with safe care. Procedures and processes guided staff on how to ensure the safety of the people who used the service.

People were provided with their medicines when they needed them. However, some people were taking their medicines mixed with food without consultation from a pharmacist to ensure it would not compromise the medicines safety or effectiveness.

There were sufficient numbers of staff to meet people's needs. Recruitment processes checked the suitability of staff to work in the service. People were treated with kindness by the staff. Staff respected people's privacy and dignity and interacted with people in a caring and compassionate manner.

Staff were trained and supported to meet the needs of the people who used the service. People's nutritional needs were assessed and met. People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

A complaints procedure was in place. People's comments, concerns and complaints were listened to and addressed in a timely manner.

There was an open and transparent culture in the service. Staff were aware of the values of the service and understood their roles and responsibilities in providing safe and good quality care to the people who used the service.

The service had a quality assurance system in place which was used to identify shortfalls and to drive continuous improvement. However, these systems had failed to identify where guidance and practice were out of date in some areas as well as where improvements were needed to the care records.

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.

Procedures were in place to safeguard people from the potential risk of abuse.

There were systems in place to minimise risks to people and to keep them safe.

There were enough staff to meet people's needs. Recruitment checks were completed to make sure people were safe.

People were provided with their medicines when they needed them and in a safe manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff understood the importance of gaining people's consent. However, the provider's guidelines relating to the Deprivation of Liberty Safeguards (DoLS) were out of date.

Staff were trained and supported to meet people's needs effectively.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

Staff were compassionate, attentive and caring in their interactions with people. People's independence, privacy and dignity was promoted and respected.

Staff took account of people's individual needs and preferences.

People were involved in making decisions about their care and their families were appropriately involved.

Is the service responsive?

Good

The service was responsive.

People were provided with personalised care to meet their assessed needs and preferences.

People's concerns and complaints were investigated, responded to and used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service had a quality assurance system in place which was used to identify shortfalls and to drive continuous improvement. However, these systems had failed to identify where guidance and practice were out of date in some areas as well as where improvements were needed to the care records.

The service provided an open culture. People were asked for their views about the service and their comments were listened to and acted upon.

Parkdale

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 unannounced inspection took place on 3 May 2016 and was carried out by one inspector.
We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the registered manager, the area manager and two other members of care staff.

We spoke with three people who used the service, two relatives and a health care professional who visits the service. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

To help us assess how people's care and support needs were being met we reviewed three people's care records and other information, for example their risk assessments and medicines records.

We looked at three staff personnel files and records relating to the management of the service. This included recruitment, training, and systems for assessing and monitoring the quality of the service.

Good

Is the service safe?

Our findings

People presented as relaxed and at ease in their surroundings and with the staff. A person told us, "Oh yes," they did feel safe.

Systems were in place to reduce people being at risk of harm and potential abuse. Staff had received up to date safeguarding training and were aware of the provider's safeguarding adult's procedures. They were aware of their responsibilities to ensure that people were protected from abuse. Details of how to report concerns was displayed in the office and both staff members we spoke with demonstrated that they were aware of the procedures. One of them told us, "I would speak to [registered manager,] depending on the concern or issue I would contact the safeguarding team, police or CQC (Care Quality Commission.)"

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks associated with using mobility equipment, pressure ulcers and falls. These risk assessments were regularly reviewed and updated.

Risks to people injuring themselves or others were limited because equipment, including electrical items, had been serviced and regularly checked so they were fit for purpose and safe to use. Regular fire safety checks were undertaken to reduce the risks to people if there was a fire. There was guidance in the service to tell people, visitors and staff how they should evacuate the building if this was necessary. There was an emergency pack by the front door which included all the information staff would need in the event that the building needed to be evacuated. This included personal evacuation plans, emergency grab sheets with key information about each person, medicines details and contact details of staff, next-of-kin and relevant emergency services.

There were sufficient numbers of staff to care and support people according to their needs. A member of staff told us, "We are never without someone here. There is always two [members of staff] sometimes three, which is nice." A relative confirmed, "There is always at least two people there. I don't think [person] has to wait. There is nothing [person] can't do because there is not enough people." The registered manager explained how they were able to make decisions about bringing in extra staff when additional support was needed. They told us, "It is all service user led,"
and went on to say, "We are not restricted, we don't have to ask permission for an extra member of staff. It's not questioned."

Recruitment records showed that checks were made on new staff before they were allowed to work in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service.

Suitable arrangements were in place for the management of medicines. Medicines administration records (MAR) identified staff had signed to show that people had been given their medicines at the right time. A robust system was in place to minimise the risk of error whilst administering medicines. Each time a medicine was administered this was checked and signed by two members of staff and the exact time it was

given was recorded. This was in addition to the entry on the MAR charts. This ensured that staff could be confident the correct interval of time had been allowed between each dose.

People's medicines were stored safely but available to people when they were needed. Protocols were in place for medicine prescribed to be taken 'as and when required' (PRN) to guide staff as to how and when these should be administered.

Staff had been trained to administer medicines safely. Regular audits on medicines and competency checks on staff were carried out. A member of staff confirmed, "I watch other [members of staff] and [registered manager] watches me. These measures helped to ensure any potential discrepancies were identified quickly and could be acted on. The pharmacy supplying the service also carried out an annual review.

Some people took their medication together with food. The service had worked with the Speech and Language Therapy team and social care professionals in carrying out assessments to establish whether this was in people's best interests. This was documented in peoples care plans, such as, "[Person] can take all medication offered in food. This is [person's] preferred method of taking medication." People who took their medicine in this way were aware that they were doing so. A member of staff told us, "We dispense medicine. We tell them '[person] we've got your medication,' so they are aware. Then we put it in the food." Although there were associated risk assessments in place, there had not been any consultation with a pharmacist to ensure the suitability of the prescribed medicine to be taken with food without compromising its safety or effectiveness. Consultation should take place before people are given their medicines in this way to ensure it is safe.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We were concerned about how the provider was ensuring that they were following up to date guidance in this area.

We saw in one care plan that best interest decisions were in place which included the statement, "[Person] lacks capacity because unable to retain information long enough to make decision – unable to weigh information to make decision." This showed it had been assessed that the person lacked the capacity to decide for themselves whether they could leave the service unattended. The guidance for staff, which formed part of the providers DoLS policy, was dated October 2013 and did not reflect current Department of Health guidance relating to DoLS. This guidance states that, to decide whether a DoLS application should be made, services should apply an 'acid test' which asks whether a person is under continuous supervision and control and whether they free to leave.

The registered manager told us that no applications had been made under DoLS to the appropriate supervisory body because it was not felt to be relevant for anyone. However they confirmed that there were people who, if they wished to leave, would be unable to do so on their own without the support of a member of staff, their family or other representative. We were therefore concerned that people were under continuous supervision and control. Without up-to-date policies and guidance from the provider, the management and staff at the service could not be sure that they were making appropriate decisions to ensure relevant safeguards were in place to protect people who may be deprived of their liberty.

We observed that staff sought people's consent and acted in accordance with their wishes. Care plans identified people's capacity to make decisions. Where people did not have the capacity to consent to care and treatment, people's representatives, health and social care professionals and staff had been involved in making decisions in the best interests of the person and this was recorded in their care plans. An assessment in one person's care plan indicated that they did have the capacity to make their own day-to-day decisions but would be supported with decisions they needed some help with; "[Person] has the support of her family and social worker for any decisions [person] is unsure of."

Staff were provided with the training they needed to meet people's needs and preferences effectively. They

told us that they felt supported in their role and had regular one to one supervision where they could talk through any issues, seek advice and receive feedback about their work practice. One member of staff commented how they felt that the part they played in the service provision was acknowledged by the management team. They told us, "It is recognised when you are doing well….if someone deserves praise it doesn't wait until supervision." This demonstrated that there was a support system in place for staff that developed their knowledge and skilled and motivated them to provide a quality service.

New members of staff were completing the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their work. There were plans for all staff to work towards completing the Care Certificate to ensure that they were up to date with their practice. A member of staff confirmed, "I've just completed NVQ (National Vocational Qualification) level three. I will be completing Care Certificate training."

Staff explained how training had been arranged in response to situations they had recently dealt with. For example, a member of staff told us, "We lost [person,] so we had end of life training." They shared the emotional impact that had been felt by the team when a person they were supporting passed away. As this was a situation that they did not often face it was felt that additional learning was needed to ensure that people, those close to them and the staff received appropriate care and support when someone was at the end of their life. This showed that the service had a proactive approach to learning and development and placed importance on staff being well equipped with the practical skills and emotional support they needed to provide a high quality of care.

People were offered a choice of what they would like to eat. A member of staff told us that, "[People] decide at their meeting what they would like on the menu." They also commented, "Just because it is on the menu it doesn't mean that they have to have it, there are alternatives available." A person told us how they had occasional takeaways and they decided what they would like to have. They also said, "Sometimes they ask me, 'what would you like?' I like salad, it's my favourite." We saw that this was recorded in the person's care plan.

The meal time experience was a positive experience. A member of staff told us, "We all like to eat together… We do involve everyone. We all speak to each other and interact." There was sufficient staff to give one-to-one support to those who needed it. We also observed that a member of staff was mindful of the assistance needed by a person who was unable to see their meal clearly. They made sure the person was aware of what was in front of them when they said, "You've got egg and bacon muffins, you've got a spoon on your right hand side in case."

People's nutritional needs were assessed and they were provided with enough to eat and drink and supported to maintain a balanced diet. People's care plans showed that there were management plans in place in relation to health conditions which could be affected by diet, such as diabetes. These showed that people were supported and encouraged to eat a diet which would help them to stay well.

People had access to health care services and received ongoing health care support where required. A person explained to us what happened if they were unwell, "I go to see a doctor." We saw records of visits to health care professionals in people's files. Records showed that specialist advice was sought when required. For example, it had been arranged for people to be visited by occupational therapists, diabetes specialists, speech and language therapist and mental health professionals. This showed that staff were aware of people's routine health needs and were proactive in involving health and social care agencies when additional support was required to help people stay well.

Good

Is the service caring?

Our findings

The atmosphere within the service was relaxed and welcoming. A person told us, "I like the place, I like the staff, I like my room, I like doing things I like.' Two people we spoke with told us that the best thing about living at the service was, "The staff."

People were positive and complimentary about the care they received. A person said that the, "Staff are kind and talk." A relative told us "[Person] is very happy there." Another person told us about their key worker, a person nominated to ensure that all their physical, social and emotional needs were being met. They said, "[Key-worker] helps me."

We observed staff demonstrating empathy, understanding and warmth in their interactions with people. A health care professional who visited the service told us that, "Staff were very caring towards the people there." Staff talked about people in an affectionate and compassionate manner and were caring and respectful. A member of staff explained how they knew what a person wanted to communicate. They commented, "Even though they can't verbally say, you know by their body language and mannerisms." This demonstrated that staff took the time to understand what people wanted to say and found ways of engaging with people who found verbal communication difficult.

Staff understood people's preferred routines, likes and dislikes and what mattered to them. A person said, "Somehow they [staff] find out what is important." Another person explained that staff knew they liked, "Listening to my music and looking at my books." When people were unable to express themselves verbally staff knew them well enough to understand what was important to them. A member of staff said, "When you get to know them you can see facially." Relatives confirmed that they felt the staff knew people well.

Care plans documented people's likes and dislikes and preferences about how they wanted to be supported and cared for. One person talked about how they were involved with their care plan and said, "I have to sign my name." As well as their physical needs, people's records included details to guide staff how to support people emotionally. One care plan included, "Staff to try to find the cause of why [person] is frustrated." This showed that staff were encouraged to take a holistic approach in the provision of care to maintain people's whole well-being.

People wherever possible were encouraged by staff to make decisions about their care and support. A person told us, "They say, do you want a wash?" This included what activities they wanted to do, what they wanted to eat and where they would like to be. A person told us, "In the evening I listen to the radio and do my [craft activity.]" This was reflected in the person's care plan.
People had been given the opportunity to have a say about how their bedroom and communal areas were decorated. One person told us about their bedroom and why the colour they had chosen was important to them.

Staff promoted people's independence by being aware of their capabilities. A member of staff told us, "We try to encourage them to do things for themselves, giving support where needed." Staff understood how

people would communicate to them the level of assistance they required. A member of staff explained, "For [person,] [they] put [their] thumbs up. It's a sign [they] have had enough help. [They] are independent." People's care plans gave details to demonstrate how people's independence could be maintained. For example, one person's care plan said, "I am able to polish and dust my bedroom and like to do this in the morning after I am dressed. I am able to make my bed but I require support from staff to change my bed linen." The person confirmed to us, "They [staff] do the floor. I can do the dusting."

People's privacy and dignity was promoted and respected. We saw in a care plan that a person had signed to say they were happy for the information it contained to be shared with others who may contribute to their care. We observed that staff were discrete in their interactions with people where appropriate. For example, one person was asked, "[Person,] do you need to go to your room?" when they were in the dining room and the member of staff wanted to check if they needed assistance to use the toilet. Staff were mindful of how they could support people to preserve their own dignity. For example, one member of staff said, "We remind them to keep their door shut, close curtains. For those that can't we make sure that happens." This demonstrated that staff recognised the importance of dignity as a core value in the service and worked together with people to promote it.

Good

Is the service responsive?

Our findings

People told us that they received personalised care which was responsive to their needs and that their views were listened to and acted on. A person told us, "When I need them, staff come in and help. I've got a buzzer." Another person said, "When I'm not feeling very well they help me."

Relatives gave positive feedback about the way support was provided and one told us that, "They [staff] are always popping in and out," chatting to the person and making sure that they are ok when they are in their bedroom. One relative felt that communication could be improved and commented, "Sometimes I feel that I don't quite know what is going on." However, they acknowledged that they were able to look at the person's care plan with the consent of their relative if they wished to do so.

Staff were knowledgeable about people and communicated with each other to pass on any changes in people's individual needs. Daily notes for each person contained details regarding daily tasks and activities, what people had to eat and drink and details about their general well-being. Staff were aware of potential triggers which could cause people distress and understood what support was needed in these circumstances. For example, a member of staff told us, "If [person] gets unsettled we say to [them] you can go out or we try to take others out. There is respect for everyone." We saw that people were reassured that any changes to their physical, social or mental health needs were identified and responded to.

Care plans were person centred and reflected the care and support that each person required and preferred to meet their assessed needs. All aspects of people's physical, emotional and social needs were considered and keyworkers reviewed the care plan documents with them each month.

Monthly reports completed by the key-workers were person centred and included changes in people's support needs. However this wasn't always reflected in the monthly monitoring records of each part of people's care plans. For example, one person's long term goal, recorded in January 2012, was to be able to eat independently. However, during lunch we observed that a significant amount of support was being given to the person and the review of this part of the care plan recorded that there was 'no change' for several months. Another person's care plan recorded in 2012 that their long term goal was to self-medicate but monthly reviews showed there had been 'no changes' since 2014. This meant that people's recorded goals were either unrealistic or were not being supported. This could be de-motivating for them as well as confusing for staff assessing the level of support they required.

Although changes in people's needs had not always been recorded appropriately in parts of their care plan, we saw that in practice, changes had been identified and steps taken to find alternative ways to provide support. For example, one person's physical health had deteriorated, meaning that the use of the hoist was necessary each time staff assisted them to move. A specialist in-situ hoist sling had been purchased which the person could remain seated on when not in use. This was more comfortable and dignified for the person because staff did not need to position a sling under them each time they used the hoist.

People told us about the activities available to them individually and as a group. One person told us,

"Monday and Wednesdays I go to the barn, It's a work centre. We do woodwork and Wednesday is pottery day." Another person commented, "I go out on Thursdays to the day centre. I go by taxi." People were encouraged to maintain independence through their daily activities. A person told us, "I help them in the kitchen…cakes, sponges, biscuits, shortcake, cheesecake." People were also encouraged to spend time with their families and people who were important to them. One person told us about their weekly stay at their family home. This demonstrated that staff were aware of the importance of physical and mental stimulation, social contact and companionship and tried to focus on what was most important for individuals.

There was a complaints procedure in place which explained how people could raise a complaint. A person commented that they had, "Never had to complain." They went on to say, "If I wasn't happy I could talk to [registered manager] or [staff member] or anybody." There had been no formal complaints to the service in the last 12 months. A relative told us that, "I've never had a complaint…If something has come up occasionally, like [person] has got the wrong laundry, it's always dealt with immediately." This showed that concerns and complaints were acknowledged, listened to and appropriate steps were taken to respond and put things right.

Requires Improvement

Is the service well-led?

Our findings

There was a person centred, open and inclusive culture in the service. A heath care professional who visited the service told us that, "The staff were approachable and the residents appeared to be well cared for."

People gave positive comments about the management of the service. One person told us how they thought of the registered manager as a member of their own family. A relative commented that the registered manager was, "Definitely" approachable, "I think [registered manager] runs it very well." A member of staff described the importance which was placed on doing the very best for people living at the service and commented, "[Registered manager] will do [their] upmost."

Staff were encouraged and supported by the management team and were clear on their roles and responsibilities and how they contributed towards the provider's vision and values. We saw that care and support was delivered in a safe and personalised way with dignity and respect. Equality and independence was promoted at all times.

Staff told us that they felt supported and listened to and that the registered manager was approachable and provided support when they needed it. One member of staff said, "If ever there are issues [registered manager] is so approachable, you can easily go and discuss problems there and then." Another member of staff told us that, "We are very well supported," and the level of support was, "Very good, especially from [registered manager]. [They] deal with whatever we can't." This demonstrated that staff were confident that they could raise any issues of concern and that these would be dealt with appropriately.

The registered manager understood their roles and responsibilities in ensuring that the service provided care that met the regulatory standards. They described the support they generally received from the provider to assist them with this and we saw that they had a close working relationship with the area manager who visited the service weekly and offered support via the telephone at other times. However, the provider had not provided the registered manager and staff with the latest best practice guidelines relating to the administering of medicines mixed with food. The service had also not been updated with regard to the latest Department of Health Deprivation of Liberty guidelines DoLS.) This mean that the provider had not consistently supported the service with the information they needed to ensure people were receiving care and support in a safe manner and in line with the current regulatory standards.

The provider had quality assurance systems in place which were used to identify shortfalls and to drive continuous improvement. However, these systems had failed to identify where guidance and practice were out of date, for example in relation to medicines management and DoLS. Although the registered manager acknowledged that they were aware of the inconsistency in some parts of the care records and had plans to rectify this, it had not been identified by the provider's audits. This showed that quality assurance systems needed to be more robust to ensure all potential shortfalls were identified and responded to.

The provider encouraged the management team to have autonomy in the running of the service. The registered manager told us, "If we need the support we can have it but we are able to make decisions." This

meant that those who knew the people living at the service and understood their needs were able to ensure that the appropriate equipment and staffing levels were provided.

People, their relatives and health care professionals had been asked to complete satisfaction questionnaires and we saw that the feedback received was positive. Action plans were put into place as a result of these questionnaires and issues which had been raised were addressed. For example, one person had requested that their bedroom was redecorated and we saw that this had been completed. This showed that people were empowered to voice their opinions and could be confident that they would be listened to and appropriate actions would be taken to improve the service.