Parkcare Homes (No.2) Limited

Newtown (65a)

Inspection report

65A Newtown
Trowbridge
Wiltshire
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
65a Newtown is a residential care home providing personal care to two people with autism and / or learning disabilities at the time of the inspection. The service can support up to three people.

People's experience of using this service and what we found
The provider did not have robust contingency plans for providing a safe service when they were short of staff. The contingency plan did not set out any rationale for the assessment that the service was safe with one member of staff in the building.

Staff had a good understanding of the support people needed. Staff were supporting people to do as much for themselves as possible.

People were supported to take any medicines safely and staff sought advice from health services when necessary.

The provider had made changes in response to the COVID-19 pandemic and there were good infection prevention and control measures in place.

People had been supported to develop detailed support plans, which were person-centred and gave staff clear information on how to meet their needs.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. Not all key questions were inspected at this time, but the service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture in relation to the Safe and Well-led key questions.

Right support: People and their representatives were involved in the creating support plans and regularly reviewing them. The service supported people to be as independent as possible.

Right care: We did not look at the caring key question at this inspection. However, we did observe some interactions between people and staff. These demonstrated genuine care for people from staff. People appeared comfortable with staff and enjoyed their company.

Right culture: People living at the service were valued for the individuals they were. People were supported to be involved in the daily running of the service and their wider community.

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

Rating at last inspection
The last rating for this service was Good (published 25 January 2018).

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service died. This incident is subject to further investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about staffing levels. This inspection examined those risks.

We have found evidence that the provider needs to make improvements. Please see the safe section of this full report. You can see what action we have asked the provider to take at the end of this full report.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 65a Newtown on our website at www.cqc.org.uk.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Newtown (65a)

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was completed by one inspector.

Service and service type
65a Newtown is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service short notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be available to support the inspection.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information

helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We looked at two people's care records. We looked at a range of other records about how the service was managed. We spoke with one person who used the service, the registered manager, deputy manager and two support workers.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with a relative of a person who uses the service and two support workers. We received feedback from two professionals who have contact with the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment;

- The provider had not ensured there were always enough staff working in the service to support people to stay safe.
- At the time of a serious incident, only one member of staff was working in the home. The registered manager told us the assessed staffing level for the evening was two staff until 10pm. The registered manager said due to staffing shortages only one member of staff was working in the service between 8pm and 10pm on the day of the incident.
- A social worker for Wiltshire Council confirmed they funded two staff to be on duty at the service until 10pm. The social worker said two staff were needed due to the needs of the three people living at 65a Newtown.
- Staff told us they did not feel it was safe for only one member of staff to be working in the service. One member of staff said they needed two staff working because incidents could escalate very quickly between the three people using the service and they needed to be aware how everyone was interacting with each other.
- The registered manager had a contingency plan for the service, which assessed the minimum safe staffing level between 8pm and 10pm to be one member of staff. However, the contingency plan did not contain any rationale setting out why one member of staff was safe or how this would enable staff to manage the risk of harm to people.

The provider had not ensured there were effective risk management systems in place to respond to staff shortages. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- The service had safeguarding systems in place and staff spoken with had a good understanding of their responsibilities. Staff had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred.
- Staff had completed safeguarding training and were confident action would be taken if they reported any concerns.

Assessing risk, safety monitoring and management

- Risk assessments were in place to support people to be as independent as possible. The plans balanced protecting people with supporting them to make choices about how they lived their life.
- People and their representatives had been involved in assessing risks and their views were recorded. The

assessments and action plans had been regularly reviewed and updated. The plans contained clear information about the support staff needed to provide to enable people to manage the risks they faced.
● Staff demonstrated a good understanding of the risk management plans, and the actions they needed to take to keep people safe.
● People had positive behaviour support plans in place where needed. These set out the support people needed to manage behaviours that challenged staff and other people. The plans included clear information about signs for staff to look out for and actions needed to de-escalate situations.

Using medicines safely
● People were supported to take the medicines they had been prescribed in a safe way. Medicine administration records had been fully completed, which gave details of the medicines people had been supported to take. Medicines were securely stored in a locked cabinet.
● Where people were prescribed 'as required' medicines, there were clear protocols in place. These stated the circumstances in which the person should be supported to take the medicine.
● Staff had received training in safe administration of medicines and their practice had been assessed, to ensure they were following the correct procedures.

Preventing and controlling infection
● All areas of the home were clean and there were clear cleaning schedules in place. The provider had introduced additional cleaning measures as a result of the COVID-19 pandemic.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong
● Systems were in place for staff to report accidents and incidents. Staff were aware of these and their responsibilities to report such events. Action was taken to reduce the risk of similar incidents happening again.
● Staff took part in reflective practice where necessary following incidents. This was used to reflect on what had happened and assess whether different actions would have resulted in better outcomes for people.
● Accidents and incidents were reviewed by senior managers to ensure appropriate actions had been taken.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of safe care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had not ensured effective contingency plans were in place to deal with a staff shortage. The staffing contingency plan did not give any rationale as to why it was safe for the service to have only one member of staff between 8pm and 10pm.
- We were not assured the contingency plan was a safe system of working in the event of staff shortages.
- There was a registered manager in post, who also covered three other services in the immediate area. They were supported by a deputy manager, who was solely based at 65a Newtown.
- The provider was working with the local authority and other bodies investigating the incident in which a person died. The registered manager and regional manager said they would implement any necessary actions that came out of the investigations.

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

- The registered manager had promoted a person-centred approach in the service. This was evidenced through the content of staff meetings, support sessions for staff and the training staff received.
- Staff reported the registered manager and deputy manager were focused on ensuring people received a good service.
- The registered manager had a good understanding of their responsibilities under the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- The service involved people and others effectively in a meaningful way. The registered manager responded to issues raised and let people know what action they had taken. A relative told us the registered manager had worked with them to resolve any concerns.
- Staff told us they felt listened to and valued by the registered manager.
- People were supported to be active members of their community and participate in local events. The service had worked to support people in different ways during the COVID-19 pandemic when they were not able to participate in their usual activities.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured there were effective contingency plans in place to mitigate risks to people when there were staff shortages. Regulation 12 (2) (a) and (b).