Parkcare Homes (No.2) Limited

Spode Close

Inspection report

6-11 Spode Close
Redhouse
Swindon
Wiltshire
SN25 2EG

Tel: 01793734778
Website: www.priorygroup.com

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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 25 September 2018 and was unannounced.

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

Spode Close is a purpose-built block of self-contained studio style apartments. The service provides accommodation and support for up to seven people with a learning disability, autistic spectrum disorder, physical disabilities or a combination of these kinds of impairment. At the time of the inspection three people were living at the service.

The care service had been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection on 13 July 2017 we had rated the service 'Requires Improvement' as we had identified breaches to legal regulations. These related to risks identified in support plans not being always followed by appropriate risk assessments, health and safety checks, auditing, and the provider not following their disciplinary procedure.

Following the last inspection, we asked the provider to complete an action plan. We needed the provider to inform us on how they intended to improve.

There was no 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. The service was run by a manager who was to become registered with the Care Quality Commission (CQC).

During the inspection we found that the risks identified in support plans were not always followed by appropriate guidance to staff on how to minimise the risks. However, despite the lack of written guidance staff were knowledgeable on how to minimise the identified risks. They were able to consistently explain to us how would they act in order to mitigate the risks. We brought this to the attention of the manager who produced a detailed risk assessment on the day of the inspection.

People's capacity was assessed in accordance with the Mental Capacity Act 2005 (MCA). However, information regarding people's consent was not always recorded. We reported this to the manager. As a result, they provided us with evidence they had recorded people's consent where needed.

There were gaps in the records. Quality assurance systems were in place but had failed to identify the issues which we found at the inspection.

People told us they feel safe. Staff had completed safeguarding training and had access to relevant guidance. They were able to recognise whether people were at risk and knew what action they should take in such instance.

Accidents and incidents were monitored and relevant action was taken to keep people safe.

Medicines were managed safely. Staff were recruited safely and in sufficient numbers, but the deployment of staff within the service did not ensure people could always participate in meaningful activities.

Staff were supported to undertake training to support them in their role, including nationally recognised qualifications. They received on-going supervision and appraisal to support them to develop their understanding of good practice and to fulfil their roles effectively.

People were supported to make choices about their food and drink. Staff ensured people received meals which suited their nutritional needs to help them maintain a healthy weight.

People told us staff were kind and caring and respected their privacy and dignity. Staff supported people to identify their individual wishes and needs by using people's individual methods of communication. People were encouraged to make their own decisions and to be as independent as they were able to be.

Activities were provided basing on people's preferences, both within the service and the wider community. However, staff told us that some staff members did not feel confident enough to take one person out for a longer period of time.

There were systems in place for people or their relatives to complain or provide feedback on how the service could be improved.

Staff and the provider understood their roles and responsibilities. The provider had a clear vision and values for the service and staff understood and acted in accordance with. The provider worked in partnership with other agencies to develop and share best practice.

People, their relatives and staff felt the service was very well managed and praised the management team. The manager was perceived as very accessible and listened to the views of others and acted on them. Staff found the manager to be approachable and felt well supported by the management team. People had very positive relationships with staff and the management, which enhanced their day-to-day experience.

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.

Where people lived with specific conditions, relevant guidance was not always in place and risks identified were not been fully addressed.

There were procedures in place to safeguard people from abuse.

There were enough staff who had been recruited safely. However, some of them lacked confidence to work with people whose behaviour may challenge.

Is the service effective?

Good

The service was effective.

The manager and staff understood their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff received the training they needed to look after people effectively.

Staff ensured people had access to external healthcare professionals when they needed it.

Is the service caring?

Good

The service was caring.

Staff knew people well and treated them with kindness, respect and understanding.

Staff provided people with good levels of support to maintain their dignity and privacy.

People were involved in making decisions about what they did during the day. They were supported to maintain and improve their independence.

Is the service responsive?

Good

The service was responsive.

Assessments of people's care needs had been undertaken and person-centred care plans had been developed to guide staff on how to support people in line with their preferences and wishes.

People had the opportunity to engage in activities of their choice and staff supported them to participate in these if they wanted to.

There was a complaints policy in place and people and their relatives knew how to complain if they chose to do so.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems were in place but these were not always effective.

There was a caring culture and good team morale amongst staff at the service.

The culture within the organisation and in the service was described as open and honest. Staff told us they felt supported by the new manager and worked well as a team.

Spode Close

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 took place on 25 September 2018 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR) prior to the inspection. 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 looked at the previous inspection report and notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

During the inspection we spoke with three people living at the service and we spent time observing care being delivered to people. We spoke with three support workers, the manager and the senior quality improvement lead.

We looked at three care plans and other records concerning the care people received. In addition, we examined records relating to how the service was run, including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection in July 2017 we had identified a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The risks identified in support plans were not always followed by appropriate risk assessments. Records did not always state the level of support needed and there were no care plans to mitigate risks related to people's specific conditions. The arrangements for monitoring people's specific conditions were not always adequate to their needs. Staff were not always appropriately trained to meet people's specific heath needs. People were not always protected from environmental risks. Health and safety checks were not regularly completed.

At this inspection we found out that the service had taken appropriate action to address most these issues. We saw records of other routine maintenance checks carried out within the home. These included regular portable appliance testing (PAT), checks of electrical equipment, fire alarm testing and water temperature checks. This showed that the provider had appropriate maintenance systems in place to protect staff and people who used the service against the risks of unsafe or unsuitable premises or equipment. Staff who administered medicines were appropriately trained and their competencies were checked at the induction. However, we found that more improvements were needed in order to keep people safe.

Due to their condition, one person could potentially self-harm themselves. There was no risk assessment addressing this issue. However, all staff were knowledgeable about the signs of the triggers of the person's behaviour. They were able to back this up with examples of proactive strategies to prevent the person's mental health deterioration and keep them as safe as possible. A member of staff told us, "When [person] gets bored, she becomes anxious. She goes very quiet before crisis. She likes stimulation, something going on every single day". We brought this up to the manager's attention and together with the PBS practitioner they produced a comprehensive risk assessment on the day of the inspection.

People received their medicine as prescribed. We reviewed people's medicine administration records (MARs) and saw staff had signed to record what medicine had been administered. Some MARs we looked had a number of missed entries. However, we were assured that the person had received their medicines as this was recorded in the person's daily notes, therefore it had no impact on the person's health and well-being. We raised this with the manager who told us they were going to carry out regular audits of record keeping to ensure records of administered medicines were accurate.

People told us they felt safe living in the service and their relatives confirmed this. One person said, "I feel safe". Another person told us, "I feel safe, it is all really good". One person's relative assured us, "[Person] is very safe. I see him once every fortnight".

Staff knew how to escalate concerns about people's safety to the provider and other external bodies and organisations. A member of staff told us, "I would report this to the manager. If nothing gets done, I would go higher".

A thorough recruitment policy and an appropriate procedure were in place. We looked at the recruitment

records for staff and saw that they had been recruited safely. Records contained application forms (including employment histories, with any gaps explained), interview records, references, proof of identity and evidence of a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with children and vulnerable adults.

People were protected from the spread of an infection. Staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was prepared safely. They wore appropriate protective clothing, food was kept at appropriate temperatures and other staff had limited access to the kitchen.

Staff told us and records confirmed there were sufficient staff to meet people's needs. A member of staff told us, "Staffing levels are generally OK".

Staff followed the colour coding system for their cleaning equipment. Colour coding is the process of designating colours to cleaning equipment in certain areas of a venue, reducing the spread of germs across areas and increasing hygiene throughout a service. As a result, the spread of a potential infection was reduced because, for example, toilet cleaning equipment was not used for cleaning bedrooms and communal areas. Staff wore protective plastic gloves and aprons when delivering personal care so as to reduce the risks of cross contamination. We observed that staff washed their hands and used hand cleansing products before performing various tasks.

There were robust contingency plans in place in case of an untoward event. The contingency plan assessed the risk of such events as pandemic or bad weather conditions and outlined how the service would continue in the event of these occurring.

All staff were trained in the use of a recognised system for supporting people to manage their behaviour when necessary. People's behavioural support plans identified the appropriate approaches for each person. We saw that all behavioural incidents were recorded, monitored and analysed by the provider's psychologist in order to manage future risk to people. Lessons learned were shared with staff and appropriate actions were taken. Records showed the service had dealt appropriately with matters according to the provider's policies using a wide range of formal and informal disciplinary actions.

Good

Is the service effective?

Our findings

People had assessments of their needs written up before they moved in to the service. People, their families, social workers and other services had been involved in the assessment process. The care plans were reviewed regularly by and a formal review was held at least once a year or even more often if necessary.

People and their relatives considered staff to be well trained. People's relatives felt staff knew their family members well. One person told us, "They know what they are doing". One person's relative complimented staff saying, "Staff are knowledgeable and always approachable".

Staff told us they had received an in-depth induction when starting work at the service. This included completing mandatory training, reading care plans and policies and spending time shadowing more experienced staff until they were competent to work independently. The induction covered topics such as first aid, fire safety, health and safety, and a recognised system for supporting people to manage their behaviour when necessary. The induction was linked to the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

Training was provided in a number of subject matters which supported staff to understand their role and how to meet the needs of people. This included training in the administration of medicines, basic life support, epilepsy, ADHD awareness, autism, and fire marshal training.

Staff told us there were enough of them on shift. However, all the members of staff we spoke with raised the issue of some staff members not being confident to work with people whose behaviour may challenge. In their opinion it had negative impact on the length of outdoor activities provided to one person. A member of staff told us, "People [staff] are hesitant to work with [person]. He can realise if people are not comfortable enough and he prefers male members of staff when we have only two male members of staff left. We take [person] to funfairs, the zoo, dining out. But this depends on who he is with. Some staff are not comfortable to take him out. Less comfortable staff let him use the computer instead or take him for a five-minute walk to a local supermarket". Another member of staff said, "I would like more activities to be provided to [person]. Going to a local supermarket to buy crisps and getting back to sit in front of the computer is not good". Another member of staff told us, "There are enough people [staff] working here bodywise, but not skillwise. It can be overcome with time". We mentioned this to the manager who told us they were going to review the activities provided to the person.

Staff had individual supervision meetings and an annual appraisal. This gave staff the opportunity to discuss any issues or concerns they had about caring for and supporting people, and gave them the support that they needed to do their jobs more effectively. However, some staff told us that due to a huge turnover of managers, matters were not always followed up as the new managers were not always aware of the issues discussed with the previous manager.

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. We spoke with staff that understood the main principles of the MCA.

We saw evidence of best interest meetings organised to make decisions about matters such as one to one support, the use of door locks or harmful chemicals and knifes being locked away.

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 found the service had submitted DoLS applications appropriately and maintained records for when these needed to be reviewed.

People told us that staff asked for their consent when it was needed and they respected their choices. We saw evidence that people were supported by staff to make choices that they were able to make. However, this was not always recorded. Staff administered medicines to one person, however, it was not clear if the person had the capacity to self-administer medicines or not. There were no records of how the service made the decision that the person was to be administered their medicines by staff, either. We brought this to the attention of the manager who together with a Positive Behaviour Support (PBS) Practitioner provided us with evidence of a mental capacity assessment and a decision making process soon after our inspection.

We asked people what they thought about the food on offer at the service and if they were provided with sufficient amounts of food and drink. One person told us, "I like the food. It is my choice what to eat and what to drink".

People's care records showed relevant health and social care professionals were involved in people's care. Health action plans were in place which described the support people needed to stay healthy. If a person needed to attend a hospital, a 'hospital passport' was available to be presented to healthcare specialists at the hospital. Such passports recorded people's specific needs and important information to ensure their needs would be met across different settings.

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind, caring and compassionate. People felt that they were listened to and made to feel that they mattered, with their individual needs being known and catered for. One person told us, "I like staff. They listen to me and take my opinions into account. I get well with all staff". One person's relative said, "He says he loves it and we trust him".

People were treated with respect and their dignity was preserved at all times. Staff showed kindness and compassion whilst providing people with care and support. We saw that staff took time to talk to people to make them feel supported and comfortable at the service. For example, we observed care staff talk to one person and then give them assistance with a drink and a snack. The person appeared to be happy to have a friendly chat with the staff member. There was friendly banter between people who used the service and staff.

Staff promoted people's privacy and we saw they knocked on people's doors to ask for permission before entering their rooms. Staff excused themselves when they needed to leave the room and explained why they had to go and when they would be back. People were addressed by their preferred names. Staff members were aware of the lifestyles people had enjoyed before they moved into the service and had good knowledge about people's relatives, interests and hobbies.

People and their relatives told us they were involved in the planning of people's care and could voice their views on how their care should be delivered. A member of staff told us, "We promote people's independence by encouraging people to choose their food. [Person] takes his plate to the kitchen, and with a right approach, he takes his laundry to have it washed".

Staff had a profound knowledge of people they supported. The care records contained information about people's personal histories and detailed background information. This helped staff gain an understanding of what had shaped people to be what they were today and how events in their past that had impacted on them. Staff were responsible for making daily records about how people were supported. They were also obliged to communicate any issues which might affect people's care and well-being to the manager, other members of team and healthcare professionals, if appropriate. Staff told us this system guaranteed that all information affecting a person's care and support was up-to-date.

People's care plans identified the appropriate individual approaches for each person. Staff knew how to comfort people who were in distress and unable to communicate their needs verbally. Staff explained to us how they read any signs of people's anxiety and described the best ways to comfort people. They said the methods of reassuring people largely depended the individual and could include re-direction, distraction or verbal and non-verbal calming down.

An equality and diversity policy was in place at the service. There were procedures for people's cultural and religious backgrounds as well as people's gender and sexual orientation to be recognised at the initial assessment stage and respected within the service. Staff received training in equality and diversity.

We saw that records containing people's personal information were kept in the main office which was locked and no unauthorised person had access to the room. People knew where their information was and how to access it with the assistance of staff. Some personal information was stored within a password protected computer.

Good

Is the service responsive?

Our findings

Staff were provided with clear guidance on how to support people in line with people's wishes and preferences. Staff showed an in-depth knowledge and understanding of people's care and support needs. All the staff members we talked to were able to describe the care needs of each person they supported. This included individual ways of communicating with people, people's preferences and routines.

The service had prepared person-oriented plans which reflected how people wanted to receive their care and support. Staff said they found the care plans useful as they gave them enough information and guidance on how to provide the support people wanted and needed. This meant that staff were able to offer very individualised care. Staff members spoke confidently about the individual needs of people using the service. The records showed people received the support they needed.

Most of the people had access to a wide range of pursuits which were meaningful to people and reflected their individual interests. Activities were important to people because they improved the quality of their lives and reduced the likelihood of social isolation. One person told us, "I have a very busy week. I go out for skating, aqua aerobic, trampolining and walks. I spend weekends with my family". Other activities included going to funfairs, shopping, eating out and other social events.

The Accessible Information Standard (AIS) framework was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. It is now the law for the NHS and adult social care services to comply with AIS. The provider checked at the initial assessment if people suffered from such conditions and recorded any sensory loss or communication difficulties in their care plans. People told us and records confirmed that information was provided to people in the way they could understand it.

People were able to express their opinions on matters important to them, such as activities, food menu or holidays, at regular house meetings organised monthly. This demonstrated that people were encouraged to share their opinion on the service and were listened to.

There was a satisfactory complaints procedure in place which gave details of relevant contacts and outlined the time scale within which people should have their complaints responded to. Staff told us they knew people well and were able to tell from their behaviour if they were unhappy and might want to make a complaint.

We found that the service helped people in the bereavement process. When a close relative of a person had passed away, the person had been assisted by a Positive Behaviour Support (PBS) Practitioner to help them through their bereavement. Staff told us this had helped the person to overcome anxiety caused by the death of their relative.

Requires Improvement

Is the service well-led?

Our findings

There was no 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. The service was run by a manager who was to become registered with the Care Quality Commission (CQC).

At our previous comprehensive inspection in July 2017 we had identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Quality and assurance systems were not always effective. The provider followed their disciplinary procedure, however, results of the internal investigation have not always been reported to the DBS.

At this inspection we found that the service had taken appropriate action to address most of these issues. Records showed the service had dealt appropriately with matters according to the provider's policies using a wide range of formal and informal disciplinary actions. Results of internal investigations were shared with the DBS where needed.

However, we found that more improvements were needed in relation to quality assurance systems. The provider had a number of systems in place to monitor the standard of care delivered to people. The quality assurance and monitoring system was in place to assess the quality and safety of the service and to ensure continuous improvements. Where audits had shown that improvements had been needed, action plans had been produced. These had been reviewed and updated to ensure that the required actions were completed and the improvements achieved. For example, some maintenance work had been done and regular weight checks had been introduced to one person. However, the systems for monitoring care quality were not always effective as they had failed to identify some issues mentioned in this report, such as gaps in the records.

Staff told us that the service lacked stable and structured management. A member of staff said, "We've had seven or eight managers in two years and this is a brand new home. They (managers) all have got their own way of working, for example, in terms of paperwork. Nothing is structured enough in this place". However, staff and people told us they were happy with the newly appointed manager. Staff told us that although the manager had taken their post a few days before, their presence was visible and made a positive impact on team morale. A member of staff told us, "I have seen the management in and out which is not good. [The manager] listens to what I am saying. He has done things straight away when I asked about training".

People and their relatives were positive about the changes in the management. One person told us, "I think [the manager] is OK". One person's relatives said, "We think the service is well-managed. They are doing a great job, much better than we could".

Monthly staff meetings were focused on satisfying the needs of people who lived at the home. Copies of staff meeting notes demonstrated that care and attention had been paid to ensure people who lived at the home

were safe and well supported. Staff told us they contributed to the team meeting agenda. We saw evidence that at the meetings staff also discussed such things as infection control issues, maintenance and staffing levels.

Policies and procedures were detailed and gave appropriate information to staff, people using the service and their relatives, and were fit for purpose. We saw that both the policies and the procedures had been reviewed. Moreover, there was a system in place for ensuring staff had read and understood them.

The manager understood their responsibilities and was aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the home and on the provider's website.