Mr Baldeep Singh Chatwal

Park House Community Care

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

The inspection took place on 2 and 4 December 2014, and was an announced inspection. The manager was given 48 hours' notice of the inspection. The previous inspection on 4 December 2013 was a follow up inspection, to look at previous breaches in the area of management of medicines. The provider had taken action and there were no breaches on the legal requirements at that time.

Park House Community Care provides care and support to adults in their own home. It provides a service to mainly older people and some younger adults and people who have a learning disability. At the time of the inspection it provided a personal care service to fewer than 20 people. It provided short visits to people as well as covering shifts over a 24 hour period to support people.

The service does not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered

Summary of findings

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 had been without a registered manager since November 2013. At the time of the inspection the manager had started to put their application together to submit to CQC to register.

People told us they received their medicines when they should. However we found shortfalls in some areas of medicine management. Where people were prescribed medicine "as required", there was a lack of proper guidance to enable staff to administer these medicines safely and consistently. Where people were prescribed "one or two" tablets, we were unable to ascertain what had been administered as staff had not recorded this detail. Staff were applying creams as part of personal care routines, but there were no proper records maintained. You can see what action we told the provider to take at the back of the full version of the report.

People felt safe whilst staff were in their homes and whilst using the service. The service had safeguarding procedures in place, which staff had received training in. Staff demonstrated a good understanding of what constituted abuse and how to report any concerns.

People had their needs met by sufficient numbers of staff. People received a service from a small team of care workers. People's visits were allocated permanently to staff rotas and these were only changed when staff were on leave. Staffing numbers were kept under constant review.

People were protected by robust recruitment procedures. Staff files contained the required information. New staff underwent a thorough induction programme, which including relevant training courses and shadowing experienced staff, until they were competent to work on their own. Staff received training appropriate to their role. However some refresher training had been delayed.

People were happy with the service they received. They felt staff had the right skills and experience to meet their needs. Staffs practice was monitored during unannounced checks on their practice. Staff felt well supported and attended supervision and team meetings.

People told us their consent was gained at each visit. People had also signed their care plan to confirm their consent to their care and support. People were supported to make their own decisions and choices. No one was subject to an order of the Court of Protection and people had the capacity to make their own decisions although sometimes people chose to be supported by family members. The manager and staff had received or were booked to attend training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People were supported to maintain good health. People told us how observant staff were in spotting any concerns with their health. The service made appropriate referrals and worked jointly with health care professionals, such as community nurses.

People felt staff were "very caring" and "helpful". People were relaxed in staffs company and staff listened and acted on what they said. People were treated with dignity and respect and their privacy was respected. Staff were kind and caring in their approach and knew people and their support needs well.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical or learning disabilities. Staff had built up relationships with people and were familiar with their personal histories and preferences.

People were involved in the initial assessment and the planning their care and support and some had chosen to involve their relatives as well. Care plans included people's preferred routines, their wishes and preferences and skills and abilities. People said the manager or a senior member of staff visited periodically to review the care plan and discuss any changes required. People said their independence was encouraged wherever possible.

People told us that communication with the office was good and if there were any queries they called the manager and they always responded.

People felt confident in complaining, but did not have any concerns. People had opportunities to provide feedback about the service provided both informally and formally. Feedback received had been positive.

Summary of findings

People felt the service was well-led. The manager adopted an open door policy and took swift action to address any concerns or issues straightaway to help ensure the service ran smoothly.

The provider had a philosophy and vision. Staff were aware of these and felt the service listened and was very caring and promoted people's independence, privacy, dignity and respect. Staff said they treated people how they would want to be treated.

Summary of findings

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. There was a lack of guidance in place for some prescribed medicines. There was an absence of records about some medicines and the amount of medicines people received.

People felt safe using the service. There were enough staff to deliver a service to people and meet their needs.

Risks to people's health and welfare had been assessed and measures were in place to keep people safe. Equipment staff used was maintained and serviced regularly.

Is the service effective?

Requires Improvement

The service was not always effective. People received care and support from trained and supported staff. However there had been a delay in some refresher training.

Staff knew people and their support needs well. Staff encouraged people to make their own decisions and choices.

People were supported to maintain good health. Staff worked with health care professionals, such as community nurses to resolve and improve health concerns.

Is the service caring?

Good

The service was caring. People were treated with dignity and respect and staff adopted an inclusive, kind and caring approach.

People were relaxed in the company of staff and people were listened to by staff who acted on what they said.

Staff supported people to maintain and develop their independence.

Is the service responsive?

Good

The service was responsive. People were involved in assessments and planning their care. Senior staff visited people to undertake a review of their care and discuss any changes.

Care plans detailed people's preferred routines, likes and dislikes and their skills and abilities.

People felt comfortable if they needed to complain, but did not have any concerns. People had opportunities to provide feedback about the service they received.

Is the service well-led?

Requires Improvement

The service was not well-led.

Summary of findings

The manager had been in post longer than six months, but the Care Quality Commission had not received an application from the manager to register with us at the time of the inspection.

Staff were aware of the provider's philosophy and vision. The principles, promoting independence, privacy, dignity and respect and treating people how you would want to be treated, were adopted by staff and reflected in their practice.

The service had systems in place to keep people informed and help ensure they received a quality service.

Park House Community Care

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 inspection took place on 2 and 4 December 2014 and was announced with 48 hours' notice. The inspection was carried out by one inspector.

The service had not been sent a Provider Information Return (PIR) by CQC prior to the inspection, due to unforeseen circumstances. The PIR 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. Therefore information that would have been submitted in the PIR was looked at during the inspection. Before the inspection, the provider supplied information relating to the people using the service and staff employed at the service. Prior to the inspection we reviewed this information, and we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We reviewed people's records and a variety of documents. These included five people's care plans and risk assessments, three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys.

During the inspection we spoke with six people who were using the service, three of which we visited in their own homes, we spoke to five relatives, the provider, the manager and five members of staff.

After the inspection we contacted six health and social care professionals who had had recent contact with the service and received feedback from two of these by telephone.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe. People told us they received their medicines when they should and they felt their medicines were handled safely. However we found shortfalls in medicines management. Where people were prescribed medicines on a "when required" basis, for example, to manage pain or constipation, there was insufficient guidance for staff on the circumstances in which these medicines were to be used and when staff should seek professional advice for their continued use. This could result in people not receiving the medicine consistently or safely.

Medicine administration records did not always show that people received their medicines according to the prescriber's instructions. When the prescriber's instructions stated one or two tablets there was no record to show exactly what medicine had been administered.

Staff were applying prescribed creams during personal care routines, but these were not detailed on the medicines administration records (MAR) charts. Care plans stated that certain creams should be applied, but daily reports showed different creams were being used. There was not always clear information about which cream should be applied where. There was a risk that creams would be used incorrectly and not in line with the prescriber's instructions.

This is a breach of Regulation 13 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff had received training in medicine administration and their practice was observed during spot checks of their practice carried out by senior staff. Staff were able to talk through the procedure they followed when administering people's medicines, which followed a safe practice.

People told us they felt safe whilst staff were in their home and would feel comfortable in saying if they did not feel safe. During the inspection there were good interactions between staff, the manager, people and their relatives often with good humour. People and relatives were relaxed in the company of staff and the manager. There was a safeguarding policy in place. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. The manager was familiar with the process to follow if any abuse was suspected; and knew the local Kent and Medway safeguarding protocols and how to contact the Kent County Council's safeguarding team.

Risks associated with people's care and support had been assessed and procedures were in place to keep people safe. For example, risks in relation to people's environment, handling their medicines and moving and handling people. People told us that they felt risks associated with their support were managed safely and they felt safe when staff moved them. People and staff told us that visual checks were undertaken on the equipment used at each visit. People said staff were quick to spot any problems and call in faults. For example, one person talked about how staff had spotted that the pump on their air flow mattress was making a noise, so staff called the supplier who visited and it was confirmed it was not working properly and repaired.

The manager told us they had a risk assessment in place in the event of bad weather. This included measures, such as access to 4x4 vehicles and staff working locally to where they lived, to ensure people would still be visited and kept safe.

People had their needs met by sufficient numbers of staff. People told us staff turned up when they were expected or "round about" and only one person had experienced a missed call. This had been reported to the office at the time, although as the relative was there they agreed to cover the lunch call. People's visits were allocated permanently to staff rotas and these were only changed when staff were on leave. Staff usually worked in a geographical area and the coordinator and manager kept staffing numbers under constant review. This was a small service and if there were high levels of sickness or an emergency the manager and senior staff covered visits. There was an on-call system covered by senior staff and the manager.

People were protected by robust recruitment procedures. Three members of staff had been recruited since the last inspection. Recruitment records included all the required information. This included an application form, evidence of a Disclosure and Barring Service (DBS) check having been undertaken (these checks identify if prospective staff had a criminal record or were barred from working with children

Requires Improvement

Is the service safe?

or vulnerable people), proof of the person's identity and evidence of their conduct in previous employments. Staff undertook an induction programme and were on probation for the first six months.

The manager told us there had been no accidents since the last inspection. They said that any accident would be investigated and action would be taken to help ensure people remained safe and reduce the risk of further occurrences. Incidents of unsafe practices by staff had been investigated and disciplinary procedures had been followed by the manager. Staff had also received additional training to reduce the risks of further occurrences and procedures had been reiterated to all staff in memo's and during staff meetings.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were happy with the care and support they received. Comments included, "They (staff) look after (family member) very well. "I cannot thank my (family member's) carer enough; she has been fantastic and made my life so much easier". "They are very good". "They do a good job".

People told us they received a service from a small team of staff. The manager told us that following an initial assessment of people's needs they matched a member of staff to cover the visits. The matching process was based on staff working in the geographical area, people's preferences and staff skills and experience. One relative told us how they had chosen this service from several, because after some discussions the manager had said they had the ideal care worker for their (family member). The manager brought the care worker to meet them when they discussed the care plan. People told us when they had not been happy with a particular care worker there had been no problem with changing. The manager told us "sometimes there is just a personality clash and we always respect this" when it has been raised by the individual. People told us they knew who was coming because they received a schedule of visits in advance.

Staff understood their roles and responsibilities. Staff had completed an induction programme, which they told us included reading, orientation, shadowing experienced staff and attending training courses. They also completed Skills for Care common induction standards, which are the standards people working in adult social care need to meet before they can safely work unsupervised. Staff had a six month probation period to assess their skills and performance in the role. The manager told us staff received initial training and this was refreshed every year or three years depending on the training subject. There was some slippage in staff receiving their refresher training and the manager told us this would be addressed in the new year and some courses were already booked. Training included health and safety, fire safety awareness, emergency first aid, infection control and basic food hygiene. Staff felt the training they received was adequate for their role and in order to meet people's needs. People felt staff had the skills and experience to meet their needs. One person said, "They (the staff) have got common sense and that's what counts".

Staff told us they had spot checks on their practice and attended staff meetings. Spot checks were undertaken unannounced whilst they were undertaking visits to people. During these observations staff practice was checked against good practice, such as infection control measures and respecting people's privacy and dignity. Staff told us they had opportunities to discuss their learning and development. Staff said they felt well supported.

People told us their consent was gained at each visit. People said consent was achieved by staff discussing and asking about the tasks they were about to undertake. One relative told us, "Yes they definitely ask and if they didn't (family member) would soon tell them". People had also signed their care plan to confirm their consent to their care and support. People said staff offered them choices, such as what to have to eat or drink. The manager told us that no one was subject to an order of the Court of Protection and that each person had the capacity to make their own decisions although sometimes people chose to be supported by family members. The manager and staff had not been involved in any best interest meetings or decisions, but understood the process, which would be followed if one was required. The manager and staff had received or were booked to attend training on the Mental Capacity Act (MCA) 2005. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People's needs in relation to support with eating and drinking had been assessed during the initial assessment. Most people required minimal support with their meals and drinks if any. People said the food staff prepared was "always done well". Staff usually prepared a meal from what people had in their home. One person and a staff member talked about how they put a shopping list together with the staff member encouraging a healthy diet as the person had a goal to lose weight. Another person told us they chose their meals and had them delivered each week, because these were healthier options than they could buy locally. One person had a specially adapted drinking vessel, which enabled them to drink independently. They told us staff always monitored how much they were drinking and if they weren't drinking enough encouraged them to drink more. Where there was a risk of poor nutrition measures were in place to reduce these risks. For example, foods were

Is the service effective?

enriched with cream, a meal supplement was prescribed by the doctor and staff monitored and recorded food and fluid intake. We saw that staff were patient when assisting people to eat and did not rush them, but went at the person's own pace.

People were supported to maintain good health. People told us how observant staff were in spotting any concerns with their health. One person told us how "carers are good like that and spot things quickly" and talked about how staff had called an ambulance recently and they had been admitted to hospital. A relative said, "They notice as soon as something is wrong and call the doctor straightaway. They need to be on the ball here and they are on the ball". Information and guidance about supporting people's health care needs were contained within their care plans, such as managing diabetes and symptoms and prevention of urine infections. Relatives confirmed, where appropriate they were kept informed about their family member's health when they were unwell. Where people were at risk of pressure sores staff were observant and called in the district nurses as soon as they were worried about an area. This resulted in joint working with nurses for a period of time with good outcomes for the person. The service was also working jointly with Marie Curie nurses and a relative told us the two services "worked well together and there was a good handover". Social care professionals told us that the service worked well with them and kept them informed about people's health and wellbeing. One professional told us, they had met with staff from the service to look at issues relating to one particular person. They felt the service took the initiative and sorted problems out, but kept them informed.

Good

Is the service caring?

Our findings

People told us staff listened to them and acted on what they said. During the inspection staff took the time to listen and interact with people so that they received the support they needed. People were relaxed in the company of the staff and communicated happily often with the use of appropriate banter and good humour. Relatives were very complimentary about the staff. Comments about staff included, “They are kind and quite capable”. They are fairly good”. “They are very caring” and “They are very helpful”.

A relative told us how very caring they thought staff were. They talked about how frail their family member had been at one point and health professionals were concerned about their family member. However through the care and dedication of the care worker treating and looking after them, they were so much better.

People told us they received person centred care that was individual to them. They felt staff understood their specific needs relating to their age and physical or learning disabilities. Staff had built up relationships with people and were familiar with their personal histories and preferences. One relative said, “(Care worker) has got to know (family member) so well”. Care plans contained details of people’s preferences although they could have better reflected details of people’s personal histories. One person told us how they had a real laugh and a joke with all the staff that visited as this was how they coped with the personal care staff carried out and if staff did not fit into this way they did not visit again.

During the inspection staff talked about people in a caring and meaningful way. When staff saw that people had not fully understood a question they quietly intervened and asked the question in a way the person would fully understand what was being asked so they did not become distressed.

People told us they were involved in the initial assessments of their care and support needs and planning their care. People said the manager or a senior member of staff visited periodically to review the care plan and discuss any changes required. People felt the care plan reflected how they wanted their care and support to be delivered. People told us that communication with the office was good and if there were any queries they called the manager and they always responded. One person told us how they had called really late at night, but this had not been a problem and she got the information she needed. One person had not known who was visiting that evening as their regular care worker was on leave. The manager contacted the office directly and let the person know. The manager told us at the time of the inspection most people that needed support were supported by their families or their care manager no one had needed to access any advocacy services.

People told us they were “always” treated with dignity and respect and had their privacy respected. Staff had received training in treating people with dignity and respect as part of their induction and their practice was checked in relation to this during the spot check visits. Information within the service user guide confirms to people that information about them will be treated confidentially. The service user guide was a booklet that was given to each person at the start of using the service, so they knew what to expect. People told us staff did not speak about other people they visited and they trusted that staff did not speak about them outside of their home. People said their independence was encouraged wherever possible. One relative told us how staff “really do give (family member) encouragement to be as independent as possible”. During the inspection people’s relatives were visiting their family member’s, but were not restricted by the staff visiting. Health and social care professionals felt people’s privacy and dignity was respected and their independence was promoted.

Good

Is the service responsive?

Our findings

People told us they were involved in the initial assessment of their care and support needs and planning their care. Some people told us their relatives had also been involved in these discussions. The manager undertook the initial assessments with a senior member of staff. In addition when contracting with the local authority they had obtained information from health and social care professionals involved in people's care and support, to make sure they had the most up to date information on the person.

Care plans were then developed from discussions with people, observations and the assessments. Care plans contained details of people's preferred daily routines, such as a step by step guide to supporting the person with their personal care, what they could do for themselves and what support they required from staff. Care plans were reviewed periodically by senior staff to ensure that any changes could be identified and reflected the discussions with people about their care and support during the inspection.

Some people were supported by staff in the mornings to ensure they were ready to go to groups and day care activities, so they were not socially isolated. One person was supported whilst their carer had a break and this time was used to spend time on a one to one to socialise and chat.

People felt confident in complaining, but did not have any concerns. One person told us they had complained and "things were sorted out immediately". The complaints procedure was contained within people's service user guide, so people knew how to complain. There had been two recent complaints regarding staffs practice. The manager had investigated these thoroughly and taken action to help reduce the risk of further occurrence. The manager had responded to the complainant explaining what action they had taken. Following the complaints the manager had introduced a new auditing tool for records and reiterated procedures at staff meetings and through feedback to staff.

People had opportunities to provide feedback about the service provided. People were asked informally for their feedback during their care plan review visit and also during staff spot check visits. Quality assurance questionnaires were sent out annually although during 2014 only a few people had completed these. Those that were returned were very positive with mostly "very good" answers and some "good" or "satisfactory". The manager told us that they planned to review the questionnaires to fit better with the new inspection measures.

Requires Improvement

Is the service well-led?

Our findings

There was currently no registered manager at the service. The previous registered manager had left and cancelled their registration in November 2013. The deputy manager took up the post of manager, but had not yet registered with the Care Quality Commission. This meant the service had been without a registered manager for longer than six months. This is a formal process and through which 'registered persons' have a legal responsibility for meeting the requirements in the Health & Social Care Act. The manager told us they had applied for their DBS check and once this was received they would submit their application to register with us. The manager worked full time in the office and was also out and about undertaking assessments, reviews and some spot checks. They were supported by a coordinator, a team leader and senior care worker. People and relatives spoke highly of the manager. They felt comfortable in approaching and speaking with them. Staff felt the manager motivated them and the staff team.

The manager told us they adopted an open door policy regarding communication. People felt communication with the office was good. Comments included, "They seem OK, all so helpful particularly in the beginning". Staff told us, the manager was very good and not judgemental and always talked things through with them.

People and relatives felt the service was well-led. Their comments included, "It's very good". "They're a good crowd". "I have nothing to compare it with, but they are very helpful and understanding" and "They try and do give satisfaction". The service was small and it was evident from discussions that any issues or concerns were dealt with at an early stage, to help ensure the service ran smoothly. Staff felt the service was well-led. One staff member said, "They are open to discussions and questions from everyone". Another staff member said, "They take our ideas and listen to our needs".

The service were members of the Kent Community Care Association and also of the United Kingdom Home Care Association. The provider told us that membership of these associations and the internet was how they remained up-to-date with changes and best practice.

The provider's philosophy and vision were included in the service user guide. Staff were aware of the philosophy of the service and told us the service was a very caring service and promoted independence, privacy, dignity and respect. They treat people how they would want to be treated.

Staff talked about how they felt the service listened to their opinions. One staff member talked about how when they suggested different ways of working on double handed calls and these suggestions had been taken on board.

The manager recognised that one key challenge ahead was no longer contracting with the local authority. The service had taken action to address this by designing flyers and other advertising materials to promote the service in the local areas. The service continues to contract with the health authority and people who fund their own care and support.

The manager was introducing a system to improve the monitoring of servicing equipment that was used by staff and this was to be contained within the care plan folder kept in the person's home. A form had been developed, which staff would record the details of the equipment used and service dates. This was to be inserted in each person's care plan within their own home.

Staff said they understood their role and responsibilities and felt they were well supported. They had regular team meetings where they could raise any concerns and were kept informed about the service, people's changing needs and any risks or concerns.

People and/or their relatives completed quality assurance questionnaires to give feedback about the services provided. During 2014 only a few were returned which were all positive. The manager told us they reviewed each returned questionnaire and had there been any negative feedback this would have been used to drive improvements required to the service.

The service produced a regular newsletter which was sent to people and staff. This was used to keep people and staff informed about news and events that were happening within the service, such as the results of the previous inspection, as well as containing reminders. For example, keeping warm in winter.

Staff had access to policies and procedures via the office or their staff handbook. These were reviewed and kept up to

Requires Improvement

Is the service well-led?

date. Records were stored securely and there were minutes of meetings held so that staff would be aware of up to date issues within the service. Care plans and risk assessments had been reviewed periodically and were up to date.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not always protected against the risks associated with medicines, because the provider did not have appropriate arrangements in place to manage medicines. There was insufficient guidance in place for staff on the use of some medicines. Regulation 13