Care Quality Commission

Parkcare Homes (No.2) Limited

# The Old Rectory

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This inspection was unannounced and took place on 28 March 2017. At the last inspection on 2 December 2015, we asked the provider to take action to make improvements in staffing levels. We received an action plan from the registered manager and at this inspection we found better deployment of staff. Members of staff told us staffing levels had improved. They said more staff were recruited and were able to support people to access the community. For example, walks, cafes and shopping trips.

The Old Rectory provides care and support for up to eight people with a learning disability, autistic spectrum disorder. At the time of our visit seven people were living at the home.

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 supported to make day to day decisions. We saw people make decisions about activities and meals. Where people lacked capacity to make specific decisions, best interest decisions were taken. The registered manager had improved the information included within best interest action plans however the best interest decisions reached were not always reviewed to ensure the decisions remained accurate. Actions plans did not provide an audit trail of the actions which included applications to Deprivation of Liberty Safeguards (DoLS) where restrictions were to be imposed.

Care records included people's life stories and care plans detailed people's preferences on how their care and treatment were to be delivered. We found care plans were duplicated and when people's need changed not all care plans regarding the same need were updated. Some care plans were not fully person centred because their ability to manage aspect of their care was not included.

Members of staff explained the procedures for safeguarding of vulnerable adults from abuse. They were able to tell us the types of abuse and their responsibilities to report abuse. We saw people approach the staff and seek interaction from them. We saw people respond in a positive manner to the staff on duty.

Risks were assessed and staff were knowledgeable about the actions needed to minimise identified risks. Risk assessments were devised on how to minimise risks identified.

The staff were supported to meet their roles and responsibilities. Staff had to attend training set by the provider as essential. The staff said the training was good, they attended refresher training and specific training to meet the needs of the people accommodated. However, the training matrix showed not all the training set as mandatory was attended by the staff

The views of people were gathered about the quality of the service. Members of staff knew people's method

of communication and knew this ensured people understood that they mattered. People were supported to access the community for example, visit to cafes. Staff responded to people when assistance was needed and to the various methods of interaction.

Quality assurance systems were in place to assess the standards of care provided. Where standards were no met action plans were developed on meeting the shortfalls identified.

## 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.

There were improvements in the staffing levels which meant staff had more opportunities for one to one time with people.

Medicine systems were safe. Where people were able staff supported them to self-administer their medicines.

Staff knew the procedures they must follow if there were any allegations of abuse.

Risks were assessed and staff showed a good understanding of the actions needed to minimise the risk to people and for people to take risk safely.

### Is the service effective?

**Good**

The service was effective.

People were able to make day to day decisions. People's capacity to make specific decisions was assessed. Documentation was to improve on best interest action plan.

Members of staff benefit from one to one meetings with their line manager. At the one to one meetings staff discussed their performance and concerns.

People dietary requirements were catered for at the home.

### Is the service caring?

**Good**

The service was caring.

People received care and treatment in their preferred manner which respected their human rights.

Members of staff were respectful and consulted people before they offered support. Staff knew people's preferred methods of communication and responded appropriately to people wishes

and accepted the manner people interacted with them.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans were not always updated following reviews; they were duplicated and inconsistent with each other. While parts of the care plan included people's preferences their ability to manage their care was not included.

Opportunities for people to participate in hobbies and interests were available.

Where complaints were received  these were investigated by the registered manager.

## Is the service well-led?

**Good**

The service was well led

Systems were in place to gather people's views.

Members of staff worked well together to provide a person centred approach to meeting people's needs.

Quality assurance systems were in place to assess the quality of care people receive.

Care Quality Commission

# The Old Rectory

**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 28 March 2017 and was unannounced and seven people were living at the service.

The inspection was completed by one inspector. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit people responded to us in a variety of methods including smiling and we spoke with the registered manager, three members of staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.  We spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for three people. We also looked at records about the management of the service.

Good

# Is the service safe?

## Our findings

We observed people were moving around the home freely. We saw people approach staff and gained the support needed. People looked comfortable and were calm in the presence of the staff. A member of staff told us they had attended safeguarding of vulnerable adults training. They knew how to identify the types of abuse and were aware they must report alleged abuse. Another member of staff told us they had attended safeguarding of vulnerable adults training. This member of staff also told us about their responsibility to report abuse they may witness from other staff towards people.

Risk assessments and care plans were in place. These included care plans for personal care, self-injuries and for reducing anxiety. The risk assessment action plans gave staff guidance on how to respond to any behaviours that were exhibited. For example, offer relaxation opportunities, offer when required medicines and to ask the person to "stop" their behaviour.

The staff explained the arrangements for managing risks. These staff knew the actions needed to minimise risk where it was identified. Another member of staff explained the actions taken to minimise risk which included continence support and restricting access to certain appliances and kitchen utensils. Another member of staff said where risks were identified actions plans were devised to minimise the risk or to support the person to take risks safely.

Risk assessments were in place to limit access into the kitchen. Where people were assessed as lacking capacity to access the kitchen independently, they were support by the staff to prepare meals and refreshments.

Incident and accidents were reported by the staff. The log of incidents and accidents showed there were four of these events in March 2017. Three incidents related to one person no longer accommodated at the service. The registered manager told us there was an investigation for a medicine error. We saw documentation that staff had taken the correct action once the error had been identified for example gaining advice from emergency services staff competency was checked. This ensured the potential of medicine errors reoccurring were reduced.

The deployment of staff had improved to ensure people were able to pursue their interest and undertake activities. Two staff said staffing levels had improved and there had been changes in the role of some staff which allowed them to spend more time with people. They said 'seniors' were no longer responsible for finding cover to maintain staffing levels. It was explained the registered manager had taken the role of finding cover for vacant hours and the on call system had also changed which meant "the pressure on seniors had lifted." A member of staff also told us new staff were recruited which improved the number of staff on duty.

The registered manager explained that although staffing levels had not increased there were vacancies in the occupancy of the home. They said recruitment of new staff had taken place but there were some remaining vacancies. We looked at the staffing rota which showed one senior and three support workers

were on duty during the day. At night one member of staff was awake and one was asleep in the premises.

The medicine management systems were safe.Where people were able the staff assisted people with the self-administration of their medicines. We saw the staff were supporting one person to self-administer their medicines at night.

The medicine file included for each person the primary healthcare professionals involved, the medicines to be administered and how the person preferred to take their medicines. Protocols for when required (PRN) medicines included the dose that can be administered within a 24 hour period. Action plans gave staff instructions to gain agreement from senior staff before administering PRN medicines. The PRN protocol for one person who at times becomes anxious gave staff guidance on the distraction techniques that must be attempted before considering PRN medicines and the behaviours the person may exhibit which indicate high levels of anxiety.

Medicine Administration Records (MAR) charts were signed by staff to indicate the medicines administered. Where PRN medicines were administered staff made a record on the reverse of the MAR chart. The reasons for administering the medicine and the dose were recorded.

Medicines were stored in a secure cabinet and staff checked the temperature of medicine cabinet daily to ensure medicines were stored within the correct temperature.

Good

# Is the service effective?

## Our findings

New staff completed an induction to prepare them for the role they were employed to perform. A member of staff told us they were shown around on the first day of their induction, shadowing more experienced staff was part of their induction. The home's induction included computer based modules and class based training to ensure all mandatory training set by the provider was attended.

This member of staff told us the training attended included epilepsy and first aid. They also stated they were registered onto the Care Certificate.
Members of staff had not attended all mandatory training set by the provider and other specific training to ensure they had the skills needed to meet people's needs. The registered manager told us the staff were working through the Care Certificate [new minimum standards covered as part of induction training of new care workers]. They said the organisation of staff to complete mandatory training was 92 percent. The training matrix provided showed 100 percent of staff had attended autism awareness training but 77.8 percent had attended safeguarding of vulnerable adults training. The registered manager said the figures did not account for the new staff on induction and there was to be an improvement once new staff had completed their induction.

A member of staff said the organisation had introduced an eLearning programme for staff to develop their essential skills and knowledge in their role. This member of staff told us they had completed refresher training in safeguarding of vulnerable adults and Mental Capacity Act (MCA) training. Another member of staff said as well as eLearning there was class based training which included Proa Act Skip [positive range of options to avoid crisis] used at the service to support people who can at times exhibit aggressive behaviour.

Systems were in place to support staff in their roles and responsibilities. The registered manager said the organisation's policy was for staff to have three monthly one to one meetings with their line manager. The matrix of one to one meetings showed staff had regular opportunities to discuss their personal development with their line manager. A member of staff said one to one meetings were regular and at these meetings they discussed concerns and were asked for their suggestions.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

MCA assessments were in place for people subject to continuous supervision and for specific decisions which included the administration of medicines and access to restricted areas. Information on the

assessments conducted were detailed. While separate best interest forms were completed following the MCA assessments these lacked detail on the actions needed for the best interest decision. The registered manager updated the best interest action plans to include the decisions made and where appropriate referrals to 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. The registered manager said DoLS applications were made for people subject to continuous supervision. We saw for one person DoLS application were made to restrict their access to the kitchen, their clothes and some electrical appliances kept in their bedroom. We discussed with the registered manager the least restrictive options were restrictions were imposed. For example relocating the televisions currently in secure glass cabinets.

Documentation within care records included people's capacity to make decisions. Personal profiles detailed people's ability to make decisions and the support relatives provided  to make complex decisions. Where people had capacity, consent to share information was sought and agreements to share information were signed by the person. For one person the agreement was signed in 2014 and was not reviewed to ensure the person continued to have capacity to take this decision.

A member of staff told us people made day to day decisions which included planning menus and what they wore. They said some people were not able to verbally communicate and made staff aware of their decisions through vocal sounds and objects of reference.  For example, one person made vocal sounds to indicate more options were needed. Another member of staff  confirmed this and said the people  used a variety of methods to communicate their decisions and their levels of ability to make decisions were varied.

Positive behaviour management plans (PBM) were in place for people that may show signs of anxiety through aggressive behaviour.  The PBM plans included an introduction to the person, triggers that indicate the person was becoming anxious and the response needed from to staff to each identified trigger. Risk assessments described the behaviour that one person may exhibit towards others when they expressed frustration. The action plans included training to be attended by the staff to gain the skills needed to manage behaviours exhibited. Also included was the guidance to staff on the actions needed to protect other people in the vicinity from potential harm.

For another person the risk assessment described the behaviours that may be exhibited following incidents where they caused harm to themselves. The risk assessment gave staff guidance on the triggers and the signs of anxiety that may lead to an aggressive incident. The action plan was for staff to distract the person and suggest ways to regain their usual behaviour also staff were to offer PRN medicines for their anxiety.

People's dietary requirements were catered for at the home. A member of staff said four week rolling menu were developed and people were asked to make suggestions of meals to be included in the menus.

The eating and drinking care plan for one person was based on encouraging the person to eat their meals in the dining room and leave their bedroom for meals. The decision was reached with the person to have meals in the quite lounge instead of the dining room. This care plan was reviewed in February 2017 and staff were to support the person with healthy eating choices. Snacks care plans were developed alongside the eating and drinking care plan for this person. The action plan was for the staff to encourage the person to eat their meals and avoid them feeling hungry in between meals.

At mealtimes we observed staff supporting people with their meals. People were asked to make a choice of their preferred meal. We saw the assistance from staff depended on the assistance needed by the person to

eat their meals.  Where staff observed people were not satisfied with the meal eaten we saw staff offer snacks such as yogurts.  People were offered drinks regularly throughout the day.

Health Action Plans ensured there was planned support from GPs and the primary healthcare team. People's medical condition was listed and included were the routine check-ups with opticians and dentist. Staff recorded the outcome of the appointments which included test results. Where specialists were involved profiles were devised to support the person with their specific condition. For example, epilepsy profiles.

Good

# Is the service caring?

## Our findings

The staff we observed were knowledgeable about people's preferences. Members of staff knew how to respond to people when they became anxious. We saw staff support people to leave the home and visit the local community throughout the inspection, for example, cafes and shops.

The home was spacious and allowed people to spend time on their own if they wished. We observed some people spent time in the communal areas or in their bedrooms. When people were sitting in the lounge we saw staff sitting with them and joined in the types of activities people used to interact. A member of staff accepted the way one person engaged with them. We saw another person gain assistance by leading a member of staff to their bedroom as this person needed support with a DVD they wanted to watch. We discussed with the registered manager how they ensured the least restrictive measures were taken for people under subject to continuous supervision. We saw the exit door into the garden were then repaired and the entry door system disarmed to give people unrestricted access into the secure garden.

Staff had a good understanding of people's individual needs. They were able to tell us about people's interests, preferred communication and how they wished to receive their care and support. A member of staff told us people were treated with kindness and they ensured people were made to feel they mattered. This member of staff said knowing the person's communication methods were important and knowing their likes and dislikes ensured they were able to speak with people in a way they understood. They also told us how staff built relationships with people. For example, reading care plans which provided guidance on how to deliver personal care in people's preferred manner. Another member of staff said getting to know people and their preferences overtime ensured people felt they mattered.

Care records included information which provided guidance to staff on the areas that were important to the person, what others liked about them, preferred activities and how staff were to support them. For one person it was documented that routines were important and the staff were not to overload the person with too much information.

The rights of people were respected by the staff. A member of staff said "I generally treat people how I want to be treated. I treat people with respect giving people options, being people's voice." Another member of staff gave us examples on how people's rights were respected. For example, giving people space and knocking on doors and waiting for an invitation to enter.

Requires Improvement

# Is the service responsive?

## Our findings

Care plans were not always current. We found as people's needs increased care plans were not updated with supplementary information instead an additional care plan was introduced. This meant the number of care plans increased and some relevant information was included which staff were expected to read. For example, staff introduced a snack and sweet care plan instead of updating to include this information into the eating and drinking care plan. For another person we saw three separate care plans for activities which included exercise, swimming and watching television instead of having an activities care plan.

We found for another person the care plan had not been reviewed once behaviours were longer exhibited. Staff told us they had input into the development of the care plans and were expected to read them. They said keyworkers [member of staff assigned to specific people] reviewed care plans with the person. Keyworkers documented the progress the person had made the previous month and followed a set agenda. For example, at all keyworker meetings staff discussed the progress made, ongoing healthcare and looked at correspondence received. A member of staff said the care plans included the information needed to care for people in their preferred manner. It was stated "from the care plans you [staff] learn how people want to be care for and [staff] build from the information." However, the staff's comments were not consistent with our findings.

For one person the care plan on reducing anxiety was developed using a traffic light system. For example, green represented "happy", amber was low level anxiety and red was upset and angry. The overview gave staff insight into the behaviours exhibited when the person became anxious. Guidance was for staff to motivate the person to participate in activities during settled periods but not to overload the person with information. The triggers for low level anxiety was noise, having to wait and the action plan included how staff were to respond to the triggers. For example staff were to spend one to one time with the person. The signs of high level anxiety were listed and action plans included the support needed from the person to each identified behaviour. For example, suggest the person go to their bedroom and for staff to say "stop" when high levels of anxiety were exhibited.

Sensory care plans were sectioned into the five senses and the impact this had on people's daily living. For example, one person may struggle with noise and another was prescribed lenses for poor sight. Communication dictionaries assisted staff to interpret people's decisions and wellbeing. For example, one person pushed the object away to indicate refusal, led the staff to the location to indicate hunger and became disinterested in activities when they were unwell.

Morning and night time routine care plans were in place on how staff were to encourage the person to manage their personal care. Where people responded to specific techniques they were detailed in the care plan. Night time routines included people's preferences on how staff were to support the person. For one person their like and dislikes and action needed by staff to support them with the patterns of behaviour.

Personal profiles included people's communication needs with their ability to engage with other people and areas of interest. Where people were not able to give information on their preferences members of staff

developed the profiles on their perception of the person. For example, the person will communicate using objects of reference and Makaton [support spoken language by the use of signs and symbols]. The overview of people's care and treatment was included in their profiles. For example, people's medical conditions, the behaviours that may be exhibited, personal and healthcare needs. Family relationships, contact were maintained and the support they provided was included.

Records of people's daily activities were maintained. We saw recorded the medicines administered, activities undertaken and meals served. We saw for one person staff had accompanied one person to the local community when they gave staff their shoes. This was an indication the person wanted to go out. The registered manager said there staff had  set one to one time with people. This gave people the opportunity to pursue interests and hobbies.

The log of complaints showed that in August 2016 one complaint was received by a relative. The desired outcome was detailed and the actions taken by the registered manager showed the complaint was resolved to the satisfaction of the relative.

Good

# Is the service well-led?

## Our findings

A registered manager was in post. Staff said there had been improvements in the deployment of staffing levels which allowed for one to one time with people.  A member of staff said the team was good and they worked well together. They said the registered manager was approachable.

The views of people were gathered during house meetings. The minutes of the most recent meeting included the names of the people present and the areas discussed. For example, equipment and activities.

Information was shared and feedback given to staff during team meetings. At the team meeting in January 2017 staff were updated about the recruitment of new staff, housekeeping issues and procedures were discussed.

Quality assurance arrangements in place ensured people's safety and well-being. The registered manager conducted self-assessments of the service and shortfalls were identified for improvement. These areas included keyworker reports, updating assessments of mental capacity and as part of the infection control audit that staff needed to wash their hands more robustly. Meetings took place with the area manager to discuss the action plan of improvements. The action plans was then monitored by the area manager.

Accidents and incidents were analysed to consider if there were any lessons to be learnt and the reduce reoccurrence. The nature of the incident, injuries sustained and the agencies that were informed about the incident. The log for March 2017 showed there were four incidents which included behaviours that challenged and one medicine error. The registered manager told us the person involved in three of the incidents was no longer living at the service.

Services that provide health and social care to people must inform CQC of important events that happen in the service. The registered manager was knowledgeable of the requirements to notify CQC of any significant events and had done so accordingly.