Review of compliance

T Chopra Parklands	
Region:	North East
Location address:	Highfield New Road Crook Co Durham DL15 8LN
Type of service:	Care home service without nursing
Date of Publication:	December 2011
Overview of the service:	Parklands care home is a converted Victorian mansion set in its own grounds. It provides up to 34 places for older people and older people with dementia care needs. It is registered to provide the regulated activity of accommodation for persons who require personal care. This home is not registered to provide nursing care.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Parklands was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 20 October 2011, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People and visitors had many positive comments to make about the way they were cared for by staff. People described staff as "kind" and "friendly."

One person said, "All the carers are very good. They look after us." People told us that they received "good care" at the home.

People told us that there were activities on some days and said "there's always something to do." However people told us that there were few opportunities to go out "because staff are so busy".

The people who lived at the home about their accommodation, "It's rather worn" and "we're hoping it's going to be better after the new building is finished."

Visitors told us, "It's desperate for an upgrade, the furniture is falling to bits."

Residents and their visitors commented that staff were "stretched". People told us that there were not enough staff on duty to help them.

One person said, "You couldn't get better staff. They go out of their way to help us, but they just haven't got enough time."

A visitor commented that staff "do their best but they haven't even got time to help people to their rooms because they are so busy." One resident told us, "Once I leave my room in the morning I can't come back all day, because I don't want to be in the lift by myself."

What we found about the standards we reviewed and how well Parklands was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Overall Parklands met this essential standard because people were treated with respect. However, to improve this, staff should have made sure that they protected people's dignity at all times.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

Overall Parklands met this essential standard because people's care needs were assessed and planned for. However, to improve this, the provider should have ensured that identified risks were clearly set out so that all staff knew how to support people in the right way.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Overall Parklands met this essential standard because there were arrangements in place to make sure people were protected from the risk of abuse.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

Overall Parklands was not meeting this essential standard. This was because the worn state of the internal decoration and furnishings did not support the well-being, dignity or independence of the people who lived here.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

Overall Parklands did not meet this essential standard. This was because staffing levels were not sufficient to meet the individual needs of the people living there.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Overall Parklands met this essential standard because staff had access to training in the needs of the people who lived here.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this

report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

We spoke with several people and their relatives during this visit. They made many positive comments about the way they were cared for by staff. People described staff as "kind" and "friendly."

One person said, "All the carers are very good. They look after us."

Other evidence
Before this visit we spoke with a care professional who had recently visited the home. They told us that they had seen staff being respectful and discreet when supporting people with personal care needs.

During this visit we saw that people could make some of their own decisions, for example about activities and meal choices. We saw that people were well supported with their personal appearance. People were appropriately dressed and were helped with hair and nail care. In this way their dignity was upheld.

We saw that staff seemed to have a good attitude towards the people using the service. We looked at the dining experience for people and saw that staff took time to answer

questions and engage with people. We saw that staff bent down to people's eye level when talking to them and held their hand.

However one staff member appeared to be a little brusque in some of their interactions with people, and spoke to them in a childlike way. For example we heard this staff say "good girl" and "finish the rest of your meal before you leave the table." This member of staff also ignored one resident's outstretched hand. This indicated that this staff member needed training in dignity and supporting people with dementia care.

We saw that three staff were supporting one person to use the main toilet off the main corridor. The toilet door had been left open, which could have compromised the dignity of that person.

Our judgement
Overall Parklands met this essential standard because people were treated with respect. However, to improve this, staff should have made sure that they protected people's dignity at all times.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

People told us that they received "good care" at this home.

They told us that there were activities on some days and said "there's always something to do."

People told us that there were few opportunities to go out "because staff are so busy".

Other evidence
We saw from the staff rota that the home employed a part-time activity staff for 15 hours a week. During this visit we saw that the activity staff was very engaged with people in the busy main lounge. People and their visitors told us that they enjoyed the activities provided. The manager said that an additional activity staff was to be appointed.

We looked at six peoples' care records. We saw that each person's needs had been assessed. We saw that each person had care plans to show staff how to support them with their individual needs, such as eating, mobility and personal care. We saw that the home's policy was to review care plans every month or sooner if there was a change in need. We saw that the care plans were reviewed monthly and that a key worker summary of the past month was also recorded. These were individualised reviews and showed each person's well-being.

We saw that some care plans had been signed by relatives or advocates to show that

they were involved and included in the care planning process. Other care plans had not been signed even if there were regular visits by the person's relatives or representatives.

There were some risk assessments in people's care files. These were about common risks such as falls and mobility. Most of the risk assessments we saw had been put into place after a recent monitoring visit by the local authority commissioners.

During this visit we saw that one new resident made attempts to leave the building. The manager told us that the person had dementia care needs and would be at serious risk of danger if they left the home without support. The manager told us that she had made a deprivation of liberty application to the local authority. (This means an agreement with care professionals about being able to restrict a person from leaving alone because it would be too unsafe for them.)

Although the home had identified this risk, there was no risk assessment record in place about this. There was no risk management plan to show staff how to support or divert the person from leaving. This meant that different staff were trying to support the person in different ways and sometimes incorrectly. We told the manager and area manager about this. They confirmed that they would put a risk assessment and risk management plan in place immediately.

Our judgement
Overall Parklands met this essential standard because people's care needs were assessed and planned for. However, to improve this, the provider should have ensured that identified risks were clearly set out so that all staff knew how to support people in the right way.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not ask people about this specific essential standard. However in discussions people and their visitors made many positive comments about the "kind" and "friendly" attitude of staff.

Other evidence
We looked at staff training records which showed that most staff had completed training in safeguarding vulnerable adults. There was a plan for remaining staff to also complete this training.

In discussions staff were clear about their duty to report any potential concerns. The home had had visits and advice from safeguarding officers from the local authority, so staff understood the safeguarding procedures.

Our judgement
Overall Parklands met this essential standard because there were arrangements in place to make sure people were protected from the risk of abuse.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
The people who lived here said of their accommodation, "It's rather worn" and "we're hoping it's going to be better after the new building is finished."

Visitors told us, "It's desperate for an upgrade, the furniture is falling to bits"

Other evidence
At the time of this visit the provider was building a new, two storey extension beside the original home. The area manager told us that this work was expected to be completed by December 2011. It was intended that the new extension would provide a 15 place specialist unit for people with dementia care needs.

We saw that the original home was warm and clean, and some bedrooms were highly personalised. However the standard of decoration and furnishings was shabby and worn. Bedroom furniture was mismatching and scratched. The bed linen was thin and would have been uncomfortable to use on the plasticated mattresses. The standard of decoration to communal toilets and bathrooms was bare and unwelcoming. (The area manager told us that a full refurbishment programme of the original home was planned to take place after the completion of the new extension.)

We saw that a sluice room with hazardous sluicing equipment was unlocked. Also the door to the sluice room had a sign stating 'shower'. This could have been confusing and hazardous for people living here. The manager agreed to remove the sign and to lock the door.

Some bedrooms were very large but had no bedhead or bedside light. This meant the people using these rooms could not switch the main light on and off without negotiating a long, risky walk.

Two of the bedrooms we checked were too cold for use. This was partly due to the draught from the gaps around the sash windows. We told the manager and area manager not to use these rooms until they could achieve the right temperature.

We were told that one person with dementia care needs had been moved to a ground floor bedroom due to their risk of falls on the stairs. However we found that this person spent much of their time going up and down the stairs on their own to sit outside their former bedroom. The manager stated that this may have been because the person's own furniture was still in the room and on the landing outside. This must have been confusing for the person and did not support their choice, independence or orientation around the home.

Some of the bedroom doors had the wrong type of lock fitted so people could not have keys to their own bedrooms. (The area manager stated that there were plans to fit new bedroom doors with built-in safety locks as part of the future refurbishment plan.)

The home had one large lounge which many people were using on the day of this visit. The lounge was very noisy, with the activity staff carrying out the activities in there, as well as being the place that most visitors used to meet with the residents. Some people said that they found the lounge too "unsettling" as some people could be "disruptive."

Some people were sitting in chairs in the hallway near the entrance, rather than the lounge. People were not using the dining room other than for meals and a former quiet lounge had been turned into a bedroom. Some people told us that they wanted to use their own bedroom for some peace and quiet, but they could not get to their room without staff support. In this way people did not have a choice of lounge areas to use. (The area manager told us that there were future plans to create more lounges as part of the planned refurbishment of the original building.)

At the start of the visit the entrance to the home was odorous but we did not find offensive odours in any other parts of the building that we visited. The area manager told us that there was a deep cleaning schedule in place to manage odour.

Our judgement
Overall Parklands was not meeting this essential standard. This was because the worn state of the internal decoration and furnishings did not support the well-being, dignity or independence of the people who lived here.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Residents and their visitors commented that staff were "stretched". People told us that there were not enough staff on duty to help them.

One person said, "You couldn't get better staff. They go out of their way to help us, but they just haven't got enough time."

A visitor commented that staff "do their best but they haven't even got time to help people to their rooms because they are so busy." One resident told us, "Once I leave my room in the morning I can't come back all day, because I don't want to be in the lift by myself."

Other evidence
We saw from the staff rotas that there were four care staff on duty from 8am to 10pm to support the personal care needs of 32 people who lived here.

The manager told us that about 20 people needed support because they had dementia care needs. The manager also told us that about 11 people had high dependencies, some of whom needed two staff to help them with personal care needs. This meant there would be only two staff to support the remaining residents. However one staff (the senior) also had to carry out medication rounds three times a day so this further reduced the amount of time that care staff had to support most of the people who lived here.

Staff told us, "With only four staff on all day, it's a lot to manage because some people have such high dependencies."

Another staff said, "We're very stretched. If one staff is escorting someone to a hospital visit, that leaves only three staff. When the senior does the meds rounds, that leaves only three staff. And when two staff are bathing someone, that leaves only two staff on the floor."

Our judgement
Overall Parklands did not meet this essential standard. This was because staffing levels were not sufficient to meet the individual needs of the people living there.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not ask people about this essential standard.

Other evidence
We looked at staff training records and talked to the area manager about staff training plans. We found that nearly all the recent training at this home had been by e-learning. This meant staff had individually completed a training exercise on the computer.

At the time of this visit two-thirds of the people living at Parklands had a range of dementia care needs. The new extension was to provide 15 'specialist' places for people with dementia care needs. All staff had completed short training exercises in basic dementia awareness and communication. Also 21 of 28 staff had completed a fuller workbook training course on understanding dementia.

The area manager told us that there were plans for staff to take part in more detailed group training in dementia care that he will provide. The area manager is a trained trainer in dementia care and is also a dementia care mapper (that is, someone who is trained to observe whether care supports the well-being or ill-being of people with dementia.)

Our judgement
Overall Parklands met this essential standard because staff had access to training in the needs of the people who lived here.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: The provider should have made sure that people's dignity was protected at all times.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: The provider should have ensured that identified risks were clearly set out so that all staff knew how to support people in the right way.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The worn state of the internal decoration and furnishings did not support the well-being, dignity or independence of the people who lived here.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The staffing levels were not sufficient to meet the individual needs of the people living there.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA