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:	June 2012
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 but community based nurses can visit if

	people have these needs.

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. Action is 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 May 2012, 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

During our visit we spoke with people who used the service and with their relatives. They said staff respected their privacy and dignity.
One person said, "They always treat me with dignity and respect."
However we found that people's privacy and dignity was not respected

People told us they were happy with the support they received with their care and welfare.
One person said, "The care I receive from these ladies is fabulous".

People told us that they were happy that staff at the home helped them to manage their medicines.
One person said, "Yes, they do the tablets every day, without fail."
However we found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place.

People told us that they were happy the premises were suitable and safe.
One person said, "They've made a very nice job."
We found that as planned, the updating of the home was not completed but progress had been made.

People told us that they had enough staff to support them.
One person told us, ""They're always busy but it has been better since more staff have been put on."

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

The provider did not meet this standard. There were not suitable arrangements in place at the home to make sure that people's privacy and dignity were supported. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

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

The provider met this standard. People experienced care, treatment and support that met their needs and protected their rights.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The provider was not meeting this standard. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

Overall Parklands was meeting this essential standard. There were enough qualified, skilled and experienced staff to meet people's needs.

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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who lived at the home were spoken with, they said,

"They always treat me with dignity and respect."

"It's lovely here, near to where I live."

"I don't have any complaints, I have everything I need."

Other evidence
People who used the service did not have their privacy and dignity respected.

When we visited we looked to see how people were supported to express their views, make decisions about their lives and how their dignity and privacy was promoted at the home.

We spent time observing how staff supported people who lived at the home. We found that staff were respectful when they talked to people, treating people with dignity and courtesy. For example, when they supported people who needed help to eat lunch they

did this by sitting next to them at a distance which was comfortable for that person. We saw that nobody was rushed, people who lived at the home were given time to respond in conversations, and we saw that staff sat down at the person's height when talking to them and referred to them by their chosen name.

However when we visited some people in their rooms we found that important confidential information about how their intimate care was to be carried out was attached onto the outside of their wardrobe doors. This highly sensitive information could have been read by any visitor to the home or other residents visiting that room and this practice did not protect peoples' dignity. We spoke with the manager who told us that this information had been stuck to wardrobe doors as a reminder for staff.

We looked at the new part of the home to see how these areas protected and promoted peoples' privacy and dignity. The rooms in this part of the home had been completed recently and people had moved there within the previous six weeks. We looked at how peoples' bedroom doors could be locked and found that four doors could only be locked and unlocked from the outside. This could have led to someone being deliberately or accidentally locked into their room. The acting manager told us that the locks were not intended to operate in this way, she arranged to have them checked and the faulty ones repaired on the day of our visit.
We then looked at how peoples' bedroom facilities supported their privacy and dignity. We found that there were no locks on the bathroom doors in all of the fifteen bedrooms of the new part of the home. We also saw that people could not lock their bedroom doors from the inside. In practice this meant that peoples' privacy could not be protected whilst they were using the bathrooms in their rooms nor could they prevent staff and other people who lived at the home from entering their bedroom at any time. This did not protect peoples' dignity because people could walk into any bedroom when, for example they were using the bathroom, resting in bed or being supported with their personal care needs.

Our judgement
The provider did not meet this standard. There were not suitable arrangements in place at the home to make sure that people's privacy and dignity were supported. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People who lived at the home were spoken with, they said,

"The care I receive from these ladies is fabulous".

"I don't have any complaints"

"The building work has been a bit disruptive but it will be for the best."

Other evidence
Care and treatment was planned and delivered in a way that ensured people's safety and welfare.

When we visited the home there were 33 people living there. We spent time talking with them, watching how staff gave them support and care. We then looked at their records with staff to see how these were used to plan, monitor and co-ordinate people's care.

We spoke with one of the care staff who told us that every person who lived at the home had a care plan. She described to us in detail how staff at the home made sure people were properly cared for and how this was written in their care plans.

We saw the home had standard documents that had been used to record each person's assessment from which a care plan had been devised so that each area of need was

supported. Those we looked at provided enough information about people's condition which had been reviewed and updated by senior staff. We looked at examples of how peoples' needs were to be met by staff. We found that every need had a list of actions that staff were to take, and that these had been written with enough detail so staff would know what they had to do. For example, someone who was unable to communicate using language had a document called "About Me" which told staff in detail all about that persons needs and preferences.

The manager told us that she had reviewed the way care plans were written to make sure they were easier to use by all staff. And that this work was continuing to improve care plans.

Where people were at risk, there were assessments which described the actions that staff were to take to reduce the likelihood of harm. For example people had nutritional assessments to make sure they were getting enough to eat. Records showed that their weight was checked regularly to make sure that they remained healthy. And some people who were at risk of developing skin pressure damage had assessments in place which showed the actions that staff were to take to avoid these. We saw that these assessments were looked at regularly by senior staff to make sure peoples' treatment was still best for them.

When we spoke with staff we found they had a good understanding of people's histories, needs and preferences which they needed to support people with a dementia type illness. From their records we saw that care staff also worked with other community-based health and social support staff such as community nurses and social workers to make sure people's wider needs were supported. All of these measures ensured people were receiving appropriate care, support, treatment and specialist support when needed.

Our judgement
The provider met this standard. People experienced care, treatment and support that met their needs and protected their rights.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who lived at the home were spoken with, they said,

"Here she comes! (staff) It's time for everyone's tablets."

"Yes, they do the tablets every day, without fail."

Other evidence
Prescribed medicines were not given to people appropriately.

When we visited the home, we looked at the medication records held on behalf of people who lived there.

We checked to see if good medication practices had been carried out and found, for example that each person's medication record had their photograph to help staff make sure that they administered medication to the right person. Detailed notes were kept on the back of the medication administration sheets which were written when any unusual events had taken place which had affected the way that medication had been administered.

Some people at the home needed to take drugs which required arrangements where they were 'controlled'. All of the controlled drugs held were stored correctly. We checked a sample of records for three medicines and found that these had been

properly administered with the correct amounts held in stock.

We checked the stock of other medicines at the home to see if records were accurate and if the number of tablets held matched with what should have been there. We found that records that had been completed by the senior in charge when they had administered medication from the homes 'monitored dosage system' (this is when the pharmacist makes up the daily amounts of medication each person needs), were accurate. This meant that the people who had their medication in this way had received the treatment they had been prescribed.

However, when we looked at records for three people who had medicines which were not in the monitored dosage system, we found that there were more in stock than there should have been.
For one person the senior in charge could not tell if they had been given one or two tablets, as they had been prescribed, because this had not been recorded so could not tell if the remaining stock was correct or if medication had been given.
We found that a further two peoples medication records for the treatment of serious illnesses did not match the numbers of medicines that should have been left in stock. The senior told us that she could not tell if they had been given the correct levels of medication or not.

We also found that for one person, the home had not made sure that their prescribed treatment was in stock and they had missed five dosages over two days. The senior in charge of medication told us that this medication would be in stock at the home later on the same day.

The manager agreed that she could not tell from the records kept if these people at the home had received the medication and treatment that they had been prescribed or not.

The manager told us that she would carry out an investigation into the administration of medicines at the home and make improvements.

Our judgement
The provider was not meeting this standard. People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who lived at the home were spoken with, they said,

"They've made a very nice job."

"Couldn't have done it better myself."

Other evidence
People who lived at this home were not protected against risks of unsafe or unsuitable premises.

At our last inspection in December 2011, we found the provider was not compliant with 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.

In response the provider sent us an action plan showing how they were going to make improvements for people at the home. This involved building a new extension as well as rebuilding and refurbishing all of the existing rooms, facilities and communal areas.

On this inspection visit we looked again at what was done at the home to make sure that people who lived there were protected by premises that were safe and to check on the progress that had been made at the home to become compliant.

We talked to the acting manager and the senior area manager who told us that the

building work at the home was presently meeting the timescale with completion planned for September 2012. The acting manager told us that the new extension had been completed on time which had allowed those people who wanted to move there from the older part of the home. This had enabled the builders to start work on refurbishing the main part of the building.

The senior manager told us that the rest of the home along with the laundry, sluice room, lounges, communal rooms and passageways would all be refurbished within the timescale. And with minimum disruption for the people who lived at the home.

When we visited, we looked around the new extension to the home. We saw that the rooms that people used were bright, airy and spacious. The premises had been built to a high standard of decorative finish, although some items such as lampshades had yet to be fitted. The acting manager told us that these were due to be delivered shortly. The furniture and fittings in this part of the home were all new.

We spoke with people who lived at this part of the home who told us that they liked this new part of the home.

We looked at the older part of the building we could see that work was taking place to change the size and layout of some bedrooms and to refurbish these and the corridor areas.

The provider was not compliant with this essential standard however we were satisfied with the actions that had been taken so far; and these were within the timescale that we had agreed with them following our last inspection in December 2011. When the timescale that we agreed with the provider has been reached, we will carry out a further visit to check if compliance has been achieved

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. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People who lived at the home were spoken with, they said,

"They have a chat and a bit of a laugh and they take me out if they have time."

"They're always busy but it has been better since more staff have been put on."

Other evidence
At our last inspection in December 2011, we found the provider was not compliant with this essential standard. This was because we found that there was not enough staff at the home to meet the needs of people who lived there.

In response the provider sent us an action plan showing how they were going to make improvements for people. They said that more staff would be recruited so that an extra care staff would be employed during the day and overnight.

On this inspection visit we looked again at what was done at the home to make sure that people were safe by having sufficient staff to support them.
We spent time from 10am to 4pm in each part of the home and found that there were enough staff available to meet peoples' needs at that time.

The acting manager told us that since the last inspection she had increased the staff at the home by one extra person per shift during the day and night.

We looked at how many staff were working on the day of our visit and found that there were nine staff including two activity co-ordinators divided between both parts of the home. We did not find any instances where people had to wait for unacceptable periods of time before they received assistance from staff. Nor did we find that peoples' needs were overlooked or they were left at risk without staff being present to support them.

We checked the staff rota to see the shifts that staff had worked and those that were being planned all confirmed that five staff were working at the home during the night and between seven and ten staff were working during the day (including trainees and activities co-ordinators). We talked to the acting manager who confirmed that additional staff had been recruited to work at the home.

Our judgement
Overall Parklands was meeting this essential standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Action
we have asked the provider to take

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider did not make sure that peoples' privacy and dignity were supported.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The provider did not make sure that people were protected from the risks of unsafe use and management of medicines.	
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.	

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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
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