Review of compliance

Parkcare Homes Limited Windsor House	
Region:	South East
Location address:	18-20 St Mildreds Road Westgate-on-Sea Kent CT8 8RE
Type of service:	Care home service without nursing
Date of Publication:	March 2012
Overview of the service:	Windsor House is run by a national private provider and provides personal care and support to up to seventeen people who have learning disabilities. Each person has their own bedroom and there are communal lounges, dining areas and kitchens. The home is near to Westgate and Margate town centres with shops and amenities. There is parking in roads near to the home.

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

Our current overall judgement

Windsor House was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 05 - Meeting nutritional needs
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 6 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

Some anonymous concerns were raised to us about the service so we carried out an unannounced inspection to look into these concerns. We found that the concerns were unsubstantiated.

People were in the lounges when we arrived and one person was helping the manager to conduct staff interviews by showing people in to the home. Some people were finishing their breakfast. All ten people who lived at Windsor House were at the home during our visit.

One person told us, "I like it here. I go out every Thursday and on Saturdays I watch football". They said that they had had a choice about moving into Windsor House.

We saw two people sitting in a smaller lounge. There were four people in a second lounge watching the television.
People appeared to be relaxed in the company of each other and the staff.

Staff looked busy with various household tasks including cooking the lunch but people using the service were not involved in these tasks. People were helped into the dining room and later ate lunch together.

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

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

People received the care and treatment they needed to remain well. However, support for activities was not planned in advance so the activity may not happen. People were not fully involved in the running of the home including the cooking and cleaning and in house activities were limited.
Overall we found that Windsor House was meeting this essential standard of quality and safety but to maintain this we have suggested some improvements are made.

Outcome 05: Food and drink should meet people's individual dietary needs

People who use the service had adequate food and drink that was varied and nutritious. Peoples' choice of food and drink was limited as they were not always aware of the menu choice options.
Overall we found that Windsor House was meeting this essential standard of quality and safety.

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

People were supported by trained staff; however, staff were not being properly supervised and appraised so their practice was not being formally checked.
Overall we found that Windsor House was meeting this essential standard of quality and safety but to maintain this we have suggested some improvements are made.

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 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
One person told us, "I like it here. I go out every Thursday and on Saturdays I watch football". They said that they had had a choice about moving into Windsor House.

We saw two people sitting in a smaller lounge and one person appeared to be asleep. There were four people in a second lounge watching the television.
People appeared to be relaxed in the company of each other and the staff.

Staff looked busy with household various tasks including cooking the lunch but people using the service were not involved in these tasks. People were helped into the dining room and later ate lunch together.

Other evidence
Each person had a support plan or care plan. The support plans had pictures, large print and photographs which made them user friendly and individual. The plans included pages entitled 'My life story' and 'My important people' so they focused on positive things about people.

Peoples' needs were recorded with what action staff needed to take to meet those needs. The plans had been reviewed regularly to check if any needs had changed. Some people needed to be checked on regularly throughout the night because of their needs. For example one care plan said to check on the person every hour. It was not clear if this happened as there was no record and the night report stated repeatedly just 'appeared to sleep through'.

The support plans included risk assessments. There was a checklist which showed what activities posed a risk which was then followed up with an assessment of that risk. This included the risk of falls. There were assessments and guidelines to show staff how to move people safely and there was equipment for staff to use including a hoist. The equipment was maintained and checked and staff were trained in how to use it properly.

How people preferred to communicate was recorded in support plans. The plan showed staff 'when I do this it means this' which was important as some people used alternative methods of communication. The menu was displayed on a notice board and was written in text which did not meet everyone's diverse communication needs, so people were unaware of what meals were planned.
Photographs of the staff on duty were displayed so that people knew who would be supporting them. Some people had been referred to an advocacy service for extra support with communication and speaking out.

Peoples' health needs were recorded as well as information about their current medication. People had regular health checks and medication reviews.

Each person had an activity plan 'What I do'. For one person the activity every morning was 'personal care' so it was not varied and there was no other activity recorded. For the afternoon we visited, the plan said the person would be going for a walk. However, this was not planned for so no member of staff was on the rota or the shift plan to facilitate this. This meant that, without forward planning, the activity was ad hoc and may not happen.

There were no activities going on during our visit apart from some people watching the television. Although staff said they had skittles and games to use, none of this was offered to people. One staff told us that it was 'up to the service user to say what they want to do'. However, some people might need support to choose from a range of options, which were not being offered. Two people were sitting in a lounge in silence without the television or radio on. One looked asleep and neither was engaged in any meaningful activity.

Staff were doing the cooking and cleaning without people who use the service being involved. This meant there was a missed opportunity to include people and increase their skills.

Each person had a goal and aspirations plan showing what personal goal they might want to achieve. One plan showed a person's goal was to increase their communication. To do this the key worker was to produce a 'communication diary'. The record was not dated and the review said 'ongoing' so it was not clear if this goal had been achieved or not. There was no record that a communication diary had been produced.
A second goal was to increase the person's daily living skills. A step by step guide had been written and showed that the person had achieved their goal.

Our judgement
People received the care and treatment they needed to remain well. However, support for activities was not planned in advance so the activity may not happen. People were not fully involved in the running of the home including the cooking and cleaning and in

house activities were limited.
Overall we found that Windsor House was meeting this essential standard of quality and safety but to maintain this we have suggested some improvements are made.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People ate their hot lunchtime meal together in the dining room. Staff had prepared the meal so people had not been involved in the preparation. One person, who uses the service, helped to lay the tables before the meal.

The menu was displayed in writing and so did not meet everyone's diverse communication needs. This meant that people may not be aware of the menu and meal choices.

Other evidence
There was a dining room that people could use to eat their meals. People usually ate together. Both kitchens were accessible and one had just been refurbished. Both kitchens appeared to be clean and organised.

There were stocks of fresh fruit and vegetables as well as meat, cereal and bread and a wide range of other foods. People could access the two kitchens for drinks and snacks and had a choice about what they ate. Healthy eating was promoted by staff who also gave regard to peoples' choices.

Special diets were catered for including soft diets. There were stocks of suitable foods to meet these dietary requirements.
People who use the service took part in the weekly food shopping trip to local supermarkets. Staff always had access to petty cash so could re stock when necessary.

Each person's care plan noted any particular needs with eating and drinking. If needed, a risk assessment was carried out to reduce risks to people when they ate or drank. Referrals had been made to the local speech and language therapy team to give some extra advice and support.

Foods that people liked and did not like were recorded so that the staff were aware. People were supported to eat their lunch discreetly and were given the time they needed. There were staff around in the dining room at lunchtime ready to give support to people.

Our judgement
People who use the service had adequate food and drink that was varied and nutritious. Peoples' choice of food and drink was limited as they were not always aware of the menu choice options.
Overall we found that Windsor House was meeting this essential standard of quality and safety.

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
People who use the service looked relaxed in the company of staff.

One person was taking part in some staff interviews by opening the front door and showing people in.

Other evidence
Staff were trained in subjects including safe moving and handling, fire awareness and safeguarding vulnerable people during an initial induction period. E learning and refresher courses were then used to update staff.
There was a training plan to ensure that staff had the training they needed. Staff had the opportunity to gain vocational qualifications.

Staff supervision and appraisals had 'been postponed until further notice' according to a sign on a notice board. The manager confirmed this saying problems with the computer system had lead to supervisions and appraisal being postponed. This meant that staff did not have the opportunity for a one to one meeting to appraise their work and an opportunity for coaching, mentoring and support.

There was a staff dress code which meant that staff would be sent home to change if they came to the service inappropriately dressed.

Our judgement
People were supported by trained staff; however, staff were not being properly supervised and appraised so their practice was not being formally checked.

Overall we found that Windsor House was meeting this essential standard of quality and safety but to maintain this we have suggested some improvements are made.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: People received the care and treatment they needed to remain well. However, support for activities was not planned in advance so the activity may not happen. People were not fully involved in the running of the home including the cooking and cleaning and in house activities were limited. Overall we found that Windsor House was meeting this essential standard of quality and safety but to maintain this we have suggested some improvements are made.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: People were supported by trained and competent staff; however, staff were not being properly supervised and appraised so their practice was not being formally checked. Overall we found that Windsor House was meeting this essential standard of quality and safety but to maintain this we have suggested some improvements are made.	

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.

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
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