Review of compliance

Parkcare Homes Limited 82 Park Street	
Region:	South West
Location address:	82 Park Street Trowbridge Wiltshire BA14 0AT
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	82 Park Street was registered in May 2011. The service provides care and support for up to 4 people with learning disabilities or autistic spectrum condition. It is one of three services registered to the manager. Parkcare Homes Limited is part of The Priory Group, a national care provider.

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

Our current overall judgement

82 Park Street was meeting all the essential standards of quality and safety.

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 1 November 2011, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People told us and indicated that they were happy living at 82 Park Street. We saw that they had developed good relationships with staff.

The service had made sure that people had looked at the home before they moved in to make sure it was suitable for them.

Members of staff understood how to keep people safe and protect them from abuse.

The manager made sure that members of staff were trained and knew how to support people with Autistic Spectrum Condition.

The manager kept the service under review to make sure that the quality of the service was improved.

What we found about the standards we reviewed and how well 82 Park Street 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

People are respected and encouraged to be involved in things that matter to them. The service makes sure that people have different opportunities to expand their life skills and experience new things.

Overall, we found that 82 Park Street was meeting this essential standard.

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

People have their care needs met through careful, detailed care planning and review. Members of staff understand how people with autism should be supported.

Overall, we found that 82 Park Street was meeting this essential standard.

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

The service makes sure that members of staff understand how people can be protected from abuse.

Overall, we found that 82 Park Street was meeting this essential standard.

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

People benefit from having members of staff around when they need them. Members of staff are well supported by management. A varied training programme means that members of staff are kept up to date with current good practice in working with people with Autistic Spectrum Condition.

Overall, we found that 82 Park Street was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Systems are in place for regular review of the quality of the service so that people are protected against the risks of inappropriate or unsafe care.

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

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People were getting ready for the day when we arrived and planning what they were going to do. Members of staff were supporting people to shower and have breakfast.

People told us that they liked living at the service and had settled in well. It was clear from observations that people had developed good relationships with members of staff.

The manager told us that people had the opportunity to spend time at the service before deciding to move in. They had decided on colours for their bedrooms and shopped for bedding with staff. The service had worked with people, their families and previous carers to make sure the transition would work well. The care plans showed that thorough assessments had been carried out before they moved in. This meant that the service could be sure they could meet people's needs and understand how they lived with autism.

People had various different activities that they were involved in. People used the facilities in a nearby hall owned by the company. There was a sensory room and a kitchen as well as art materials. People liked to use the musical equipment there. The manager told us that she had held a cake making competition with one person. The cakes were to be baked that evening and judged the next day.

Other things people had done included visits to: Trowbridge Museum, Bath, a local water park and the New Forest. Some people volunteered with local charities, such as, the British Heart Foundation shop. Some people were involved in the local Gateway Club. People used public transport as well as the service's own vehicles. People's weekly programmes identified times when they spent time on their own, described as 'chill out'. People could choose what they wanted to do and liked to have a structured plan of activities. The manager was looking at people accessing other local activities, such as learning opportunities at a local agricultural college. She gave examples of some people doing things that they thought they wouldn't like to do, for example, swimming.

People had detailed communication plans. Some people used Makaton gestures to communicate. Makaton is a communication vocabulary often used by people with learning disability. Members of staff told us that they had been trained in Makaton as part of their induction. Some people used their own gestures to communicate and these were recorded in their care plans. There was paper and pencils available if people wanted to draw pictures to express themselves. The manager told us that she was getting to know more about how people communicated. She gave some examples of how people had communicated in ways that had not been apparent in their previous placements.

People met each week to discuss their individual menus for the week. Some menus could be produced in pictorial format. People could have their own cupboard in the kitchen to store their food items. The facilities were large enough for more than one person to prepare food at a time.

Other evidence
The service opened in July 2011. All the bedrooms had ensuite shower and toilet facilities. The manager had been involved with the planning stages for the layout of the building. She told us that in choosing the decoration, she had taken into account people's sensory needs such as neutral, but different colours for the communal areas.

The manager went to the local residents' association meetings. She said that this had developed strong links with the community and given a better understanding of the needs of people with autism.

This was one of three services that the manager was registered for. She told us that she spent a dedicated amount of time in each of the services. This was formally recorded so that everyone knew when she was available. We saw that people could come and talk to the manager in her office because it was located within easy walking distance, in the activity hall. The manager had written people's individual goals on a white board in her office. People came to tick them off when they were achieved and write new ones.

Our judgement
People are respected and encouraged to be involved in things that matter to them. The service makes sure that people have different opportunities to expand their life skills and experience new things.

Overall, we found that 82 Park Street was meeting 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 had detailed care plans which set out how their needs were to be met. Care plans were accessible to people because they had symbols, pictures and words. The daily notes reflected those aspects of each person's care plan which staff reported on. Risks of daily living were being assessed. People were encouraged to take measured risks to increase their self esteem, gain life skills and reduce risk of social isolation. The assessments were linked to the care plans, showing how people would be supported to achieve a positive outcome. Each person had an individual fire evacuation plan.

People had health action plans which detailed all aspects of their health and welfare needs. The service had sought information from families, previous carers and healthcare professionals before people moved in. People were weighed when they moved in. Then they were weighed at other times, depending on their nutritional risk assessment. There was information about how people expressed when they were in pain and what staff should do to support them. The manager told us that people's sense of touch, smell, hearing, heat and sight were taken into consideration in their health action plans.

Behaviour support plans showed how people expressed agitation or anger. There was clear guidance on recognising how to reduce people's responses to situations, changes or actions of others. Members of staff had trained in managing and reducing behaviours. Following incidents, the manager met with staff to discuss the issues and the way forward.

People's care plans had been reviewed and updated as their needs changed and members of staff got to know them better. Everyone had a keyworker. They were required to write a progress report to the manager each month.

People's ability to manage their own medicines had been assessed. One person showed us their medicine cabinet in their bedroom. They said that they called a member of staff when they were ready to take their medicines. They showed us the medicine administration record where they signed to say that they had taken the medicines. The person checked each medicine with the member of staff against the medicine administration record. They also recorded the temperature of the cabinet each day. The manager told us that people were being supported to be more independent with managing their medicines.

Other evidence
We asked about people's choice when being supported in intimate personal care by male and female staff. Members of staff told us that it had been made clear to them at induction what care and support they could provide to people of a different gender. People's choice was noted in their care plans for personal care. The manager told us that she had not yet received the full range of the new provider's policies. She said she would request the gender working policy.

Our judgement
People have their care needs met through careful, detailed care planning and review. Members of staff understand how people with autism should be supported.

Overall, we found that 82 Park Street was meeting this essential standard.

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 asked members of staff about safeguarding vulnerable people. They told us about the internal reporting procedure and told us that they had copies of the local safeguarding procedure booklet entitled No Secrets in Swindon and Wiltshire. The staff talked about the company whistle blowing procedure which was on the notice board. They said there were telephone numbers and photographs of various senior managers in the company who they could contact if the manager was unavailable in an emergency. One member of staff told us that they had been asked about safeguarding at their job interview.

Some people managed their own money. Risk assessments were carried out to see if people were vulnerable if they managed their own money. People could keep small amounts of cash in the safe. Records and receipts were kept of all transactions.

Other evidence
No one was subject to a Deprivation of Liberty Safeguards authorisation. People's mental capacity had been assessed for different reasons. People had advocates if they needed support with making some decisions.

Our judgement
The service makes sure that members of staff understand how people can be protected from abuse.

Overall, we found that 82 Park Street was meeting this essential standard.

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
Members of staff told us that there must be at least two members of staff on duty over a 24 hour period. At night a member of staff slept while the other stayed awake. The rota showed where people had one to one time with staff. The manager was consulting with staff about changing the current rota system to meet the needs of people better. One benefit was that on some days people could go out on trips without having to get back before staff went off duty.

The service could call on support from members of staff from another service which was within walking distance. There were four other services for people with Autistic Spectrum Condition in Trowbridge. This meant that members of staff could cover shifts when needed in any of the services. No agency staff were used.

We asked members of staff about their induction and training. They told us that they had shadowed a more experienced member of staff at one of the other services for three weeks. They said they had an induction pack which they worked through. Members of staff had had previous experience of working with people with autism and with family members. One member of staff told us that they had trained in Aspergers Syndrome.

The company provided a programme of training for staff. The manager told us that the company's specialist in Autistic Spectrum Condition was providing training to managers. The manager planned to provide training that linked to each individual person's complexity. The deputy manager had trained in intensive interaction and provided the training to members of staff. This is a recognised way of working with people who have

difficulty communicating, to help them communicate better in their own way.

Members of staff told us about their recent training which included safe handling of medicines, moving and handling and food hygiene. There was e-learning as well as face to face sessions. The manager kept a record of which training members of staff had completed and which needed updating. Specialist outsourced training had included epilepsy and mental health.

One member of staff told us that they were just finishing the Diploma in Health and Social Care. The manager had a degree in supporting people with autism. She told us she was half way through a Bachelors degree in life science.

The manager told us that people were involved in meeting and talking to potential members of staff with staff support. The manager said she took into consideration people's comments and staff observations of how the candidates interacted with people who used the service.

We asked about staff receiving regular supervision. The manager told us that staff supervision had not taken place as often as she would have liked. She showed us her diary where she had put in each team leader's supervision sessions for the next few months. The team leaders would then supervise the other members of staff. The manager was undertaking staff appraisals. She told us that she had changed the handover times so that members of staff communicated better and were kept up to date with important things.

Other evidence
An administrator had recently been recruited. The manager said that this meant more time for management and staff to spend with people because they were not involved in office tasks.

Our judgement
People benefit from having members of staff around when they need them. Members of staff are well supported by management. A varied training programme means that members of staff are kept up to date with current good practice in working with people with Autistic Spectrum Condition.

Overall, we found that 82 Park Street was meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The company had carried out two audits of the service since it opened in July 2011. The manager showed us the action plans and how issues had been addressed. The manager had her own system for staff to report on the service, such as the weekly environment safety check and a check on whether the menus were nutritionally healthy. The manager was setting up meetings so that people could talk about the service and hear what action had been taken on their inputs. The manager was looking at other aspects of the service with a different theme each month, for example, language and attitude.

Other evidence
The manager told us that she had an evening meal with people at least one night a week. This meant that people could talk about things on a more informal basis.

Our judgement
Systems are in place for regular review of the quality of the service so that people are protected against the risks of inappropriate or unsafe care.

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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