Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

The Waves

199 Churchill Road, Parkstone, Poole, BH12 2JD

Date of Inspection: 11 June 2013 Date of Publication: July 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Harbour Care (UK) Limited
Overview of the service	The Waves is a care home without nursing in Poole for up to three people with learning disabilities.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and talked with commissioners of services.

What people told us and what we found

During the inspection there was one person living at The Waves. The purpose of the inspection was to follow up on the compliance actions issued at the last inspection.

The individual had complex needs and communicated with us and staff by using 'Makaton' a type of sign language. We spoke with two staff and the manager.

We saw that the individual was very relaxed with the staff. They laughed and Makaton signed with the staff. Staff understood the individual's needs and how they communicated.

Where people did not have the capacity to consent, decisions were made in consultation with people's representatives and health and social care professionals.

People experienced care and support that met their needs and protected their rights. Risks to people, staff and others were assessed and managed to ensure the safety of all parties.

There were systems in place to regularly check and monitor the quality of the service.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases

we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

At our inspection on 11 January 2013 we found that care, support and risk plans did not evidence that they had been developed in consultation with professionals and relevant others. It was recorded on these plans that the individual did not have capacity to consent.

The provider sent us an action plan following the inspection detailing how they planned to address the shortfalls identified.

At this inspection we found that there had been a review in April with the individual's parents and the care professionals. The care plans and 'best interest decisions' had been signed and agreed by the individual's parents. This showed that the original Mental Capacity Act assessment and the subsequent 'best interest decisions' about restrictions had been reviewed and agreed. The manager informed us that they were waiting for the final minutes from the 'best interest' meeting held in April 2013.

The staff we spoke with had an understanding of the Mental Capacity Act and the 'best interest decisions' in place. They were able to describe how they supported the individual to make choices and to seek their consent where they were able to.

We saw that staff asked the individual if we could sit in the lounge with them. They also asked the person by Makaton signing if we could look at their care plan. The individual agreed to this by handing us their care plan and turning the pages for us.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

At our inspection on 11 January 2013 we found that bespoke arrangements were not place to deal with foreseeable emergencies.

The provider sent us an action plan following the inspection detailing how they planned to address the shortfalls identified.

We looked at the individual's care plans, care records, risk assessments and emergency plans in place.

At this inspection we found that there were arrangements in place to deal with foreseeable emergencies. There was an individual plan in place for what action staff needed take and how the individual was to be supported. This included being accommodated at another care home within the organisation in exceptional circumstances. The plan was specific to the individual and reflected their specialist and complex needs.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Since the last inspection the individual's care plan had been updated and new risk assessments and management plans had been completed. These were clear and easy to follow.

We spoke with staff and they were very knowledgeable about the individual and their care and support needs. We observed good relationships between the individual and staff. Staff understood the individual's communication and all of their Makaton signs. This meant that the individual was relaxed and was able to make their needs understood.

We saw from records that the individual's health care needs were met. They had received dental treatment and had regular medication reviews with the GP. Staff described how the person had started to Makaton sign when they needed pain relief. There were clear records that showed that staff were closely monitoring specific areas of the individual's health.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

At our inspection on 11 January 2013 we found that there was no recorded risk assessment identifying the risks to staff and others that might occur in the delivery of the care and support. There were no risk assessments in place that explained to staff how they should respond to behaviours to keep themselves and others safe.

The provider sent us an action plan following the inspection detailing how they planned to address the shortfalls identified.

We looked at the care and risk management plans in place for the individual. They included clear information as to how staff and others were to keep themselves safe during any incidents when the individual may present challenges. This included the use of a locked door for a very short period of time. This had been agreed as a 'best interest decision' by professionals, staff and relatives. We saw that Deprivation of Liberties Safeguards had been considered by the authorising body. The authorising body had deemed that an application was not required.

Staff we spoke with told us that the individual was starting to manage their own behaviours and would take themselves to a separate space away from staff. We saw that any incidents were reviewed every month and there had been a significant reduction in incidents and the duration of incidents.

We looked at the individuals 'traffic light' plan. This was a behaviour management plan that helped staff to understand individuals' mood and emotions and guided staff to offer appropriate support to keep the individual and themselves safe. Staff were able to describe how they supported the individual and what they said reflected the plan.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

At our inspection on 11 January 2013 we found that quality assurance systems had not assessed and managed the risks to the health, welfare and safety of people living at the home and others.

The provider sent us an action plan following the inspection detailing how they planned to address the shortfalls identified.

The manager explained the different ways that they consulted with the individual's representatives and staff. The person's relatives visited the home three times a week and they had signed and agreed the individuals care plan. Staff told us that they are a small team and that they are well supported by the manager. They told us that they are listened to and are kept updated about important things.

The provider undertook an unannounced visit to complete an assessment of the home against the sixteen essential standards of quality and safety. The manager informed us that they had then produced an action plan that they had to update on a monthly basis and when they had completed the actions.

We saw that each month a review of all aspects of the individual's care, health, support and behaviours had been reviewed. From this a monthly summary report was produced and actions needed were identified and followed up. This review included auditing the individual's care and risk management plans.

There was evidence that learning from incidents/investigations took place and appropriate changes were implemented. We found that all behavioural incidents had been reviewed for the individual and summarised. These had been entered on to a computerised system so they could also be reviewed by the provider as well as the home's manager.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – 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.

Moderate impact – 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.

Major impact – 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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