Review of compliance

Autism West Midlands Pinetrees	
Region:	West Midlands
Location address:	36 Kensington Road Selly Park Birmingham West Midlands B29 7LW
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Pinetrees is a residential care home for up to four people who have autism.

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

Our current overall judgement

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

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

Why we carried out this review

We carried out this review 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 12 March 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

We met with all of the people who lived at the home. We observed the way care workers supported people throughout the time of our visit. We heard people being spoken with in a friendly and kind way and the atmosphere in the home was pleasant and lively. One person who lived at the home told us "It's a good place to live."

People told us they felt safe living there. One person told us "If I was worried about something I would talk to my key worker."

People had individual activity planners which showed what activity they would be undertaking each day. One person who lived at the home told us "I go to tea rooms, art galleries and the library. I do lots of things."

We asked people who lived at the home if there were enough care workers. One person told us "We are okay for staff, not brilliant but satisfactory." Another person told us there were enough care workers.

What we found about the standards we reviewed and how well Pinetrees 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 who live at the home are involved in their care which is delivered in a respectful way.

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

There are systems in place so that people receive effective, safe and appropriate care and support that meets their needs and protects their rights.

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

There are systems in place so that people who use the service are protected from abuse.

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

There is a risk of poor outcomes for people from inadequate planning and assessment of staffing needs.

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

There are systems in place to capture the views of people that use the service and to assess and monitor the safety and quality of care.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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
We met with all of the people who lived at the home. We observed the way care workers supported people throughout the time of our visit. We heard people being spoken with in a friendly and kind way and the atmosphere in the home was pleasant and lively. One person who lived at the home told us ''It's a good place to live.''

We saw throughout our visit that the interactions between people and care workers were very positive. Care workers supported people in what they wanted to do and helped people make decisions about their daily life. Records showed that weekly meetings were held with people who lived at the home so they had an opportunity to express their views about the support they had and what things they would like to do. People who lived at the home took it in turns to chair these meetings. One person told us they had been discussing what they could do to celebrate the 2012 Olympics.

Regular review meetings were held with people to discuss their care. People who lived at the home told us they were included in any decisions made about their care. One person told us ''I see my care plan and talk to staff about it.''

People were supported to record the outcome of their own appointments in their health action plans. These documents were presented in a picture and photograph format so

they were in an easy to understand format. This ensured that people were fully supported to take control and manage their own health care.

Other evidence
We had no other evidence.

Our judgement
People who live at the home are involved in their care which is delivered in a respectful way.

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
We spent time with people who lived at the home, observed how they were being supported and asked care workers about people's needs.

We looked at the records of two people who lived at the home to see if care was being provided in the way that it had been planned. We saw that the care files contained detailed plans explaining to care workers what people could do for themselves and how they wanted care workers to support them. The care plans covered areas such as accessing the community, medicines, management of money and personal care.

The care plans had been written with the involvement of the people living at the home and set out what care workers needed to do to meet their needs. Consideration had been given to people's cultural and religious needs as part of their care plan. We saw that the information was detailed and included information about people's preferences. We spoke with care workers during our visit who showed they had very good knowledge of people's individual care needs.

There were assessments and plans in place to make care workers aware of difficult to manage behaviours. These records detailed what circumstances made these behaviours more likely to occur, how to minimise them happening and what to do if they did occur.

We found that people were being supported to see the GP, dentist, optician and specialist health workers. We saw that people had a health action plan. This contained

information about people's health care needs and visits from health professionals.

People living at the home were encouraged to gain skills and independence. People were involved in undertaking day to day housekeeping tasks. We saw that care plans recorded what people liked and disliked in terms of food and leisure activities. People had individual activity planners which showed what activity they would be undertaking each day. For example, this included German lessons, meals out and swimming. One person who lived at the home told us "I go to tea rooms, art galleries and the library. I do lots of things."

We had lunch with people living at the home during our visit. People had home made soup and sandwiches. People told us they were happy with the meals at the home.

Other evidence
We had no other evidence.

Our judgement
There are systems in place so that people receive effective, safe and appropriate care and support that meets their needs and protects their rights.

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 spoke with four people who lived at Pinetrees. They told us they felt safe living there. One person told us "If I was worried about something I would talk to my key worker."

Records and discussions with care workers showed that they had received training on safeguarding people from abuse. We asked three care workers what action they would take if they were aware people might be at risk from abuse. They were all able to describe the action that they would take to keep the person safe. We found there was information on display available to people who lived at the home and to care workers about how to report abuse.

We found that care workers had received training about the Mental Capacity Act. The Act governed decision making on behalf of adults, and applied when people did not have mental capacity at some point in their lives for specific decisions. We found that there were leaflets available in the home telling people about the Act.

Other evidence
People had support from staff to manage their money. Money was being stored securely and we saw care workers checking that people's money was correct.

Our judgement
There are systems in place so that people who use the service are protected from abuse.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We saw that care workers spoke to people in a friendly and kind way, and helped them when they needed it. We saw that people living at Pinetrees looked relaxed and comfortable in the presence of care workers. Care workers that we spoke with confirmed that they had received the training they needed and that regular updates were available.

We asked people who lived at the home if there were enough care workers. One person told us "We are okay for staff, not brilliant but satisfactory." Another person told us there were enough care workers.

During our visit we saw that care workers were available to support people when needed. However the rota showed that often at weekends there was only one care worker on duty. Care workers told us that they liked to have two care workers on duty in the evening but that sometimes there was only one. However, care workers told us that staffing levels did not put people at risk. One care worker told us "One staff is okay, it's not unsafe." Another care worker told us "There have been no behaviours that I have struggled to deal with when lone working. We have behaviour guidelines, behaviours have gone right down, things go well."

We had previously received information from the registered manager that told us a risk assessment had been completed about staffing levels at the home. We asked for a copy of the assessment after our visit, but were told this was not available. We were informed it had been completed over 18 months ago and had not been kept up to date.

Rotas showed that care workers sometimes worked long hours on their own. Care workers sometimes worked a late shift, then slept at the home, followed by an early shift. Care workers told us that the shift was long but that they were used to it. A risk assessment regarding lone working had been completed but this did not identify the level of risk and lacked detail about the control measures in place.

Other evidence
We had no other evidence.

Our judgement
There is a risk of poor outcomes for people from inadequate planning and assessment of staffing needs.

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
We found that there were a variety of systems in place to assess and monitor the quality of the service being provided.

An annual survey was completed by people who lived at the home about their views of living there. We found this had been completed in January 2012. People were positive about where they lived.

A variety of internal audits were completed including health and safety, fire procedures and medicines. We found evidence that where improvements had been identified as needed then action had been taken. For example, a fire risk assessment had identified that a fire drill was needed. We saw this had been carried out soon after it was identified as needed.

The registered provider's operational manager visited the home regularly to talk with the people who lived there and care workers. One person who lived at the home told us that the operational manager asked them how they were when they visited. We were told these visits were informal and there were no written reports completed from the visits.

Other evidence
The registered manager told us about a new peer review process that was to start next month where managers from other Autism West Midlands homes would visit each other's homes to share ideas and areas for improvement.

We saw that information about how to make a complaint was on display in the home. The complaints log showed that no recent complaints had been received.

Our judgement
There are systems in place to capture the views of people that use the service and to assess and monitor the safety and quality of care.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There is a risk of poor outcomes for people from inadequate planning and assessment of staffing needs.	

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

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

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

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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