Review of compliance

Autism Anglia Whitstone House	
Region:	East
Location address:	Whitstone House 49 Norwich Road Dereham Norfolk NR20 3AS
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	Whistone house is registered to provide accommodation for up to 11 people with a learning disability and who require nursing or personal care. The registered provider is Autism Anglia and their head office is based Colchester, Essex.

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

Our current overall judgement

Whitstone House 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, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

Although the majority of people living in Whitstone house could not communicate tehri views verbally, they showed many signs of well being. They interacted confidently with staff and were able to make their needs known by using a simple sign language.

People living in Walnut house were able to communicate their views and stated that they "liked the staff and that they are taken on nice holidays and out for lunch." Another person we spoke to said that they "Liked the staff and that people take me out to my daycentre." One person was also happy to show the inspector around the home showing that they were proud of where they lived and showed many signs of well being.

One person spoken to said that they "Liked the staff and that they were kind." Three people spoken to in Walnut house all felt that staff "were kind," caring and that they felt safe".

One person said that if they had a problem they would "Go to the staff and report it." People living in Walnut house were able to confirm that they have regular service user meetings with one person stating that they "like meetings with their friends and the staff."

What we found about the standards we reviewed and how well Whitstone House 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 treated with dignity and respect. They are involved in decisions about their day

to day lives.

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

People have a plan of care but some are incomplete whereby records do not always identify individual risk.This means that people may not be always be consistently receiving the care they need.

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

People living in the home are sufficiently protected due to effective systems in place for the reporting and recording of safeguarding.

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

There is a lack of evidence to confirm that all staff are provided with the necessary training to carry out their role effectively.

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

Quality assurance and monitoring is not yet fully developed in order to monitor and improve outcomes for people who use the service.

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
Although the majority of people living in Whitstone house could not communicate verbally, they showed many signs of well being. They interacted confidently with staff and were able to make their needs known by using simple sign language.

However in Walnut House everyone was able to communicate their views and stated that they "Liked the staff and that they are taken on nice holidays and out for lunch." Another person we spoke to said that they "Liked the staff and that people take me out to my daycentre." One person was also happy to show the inspector around the home showing that they were proud of their home and appeared both relaxed and content.

Other evidence
The needs of the people living within Whitstone house can often be challenging and unpredictable. However there were no inappropriate or negative behaviours seen by staff during an incident of challenging behaviour, during our visit. Staff we spoke to stated that they endeavour to involve families as much as possible and will interact with the development of care plans for those people who are unable to voice their own opinions. Care plans seen have been completed with either the person themselves or with the family member where possible.

During our observations throughout this visit all people seen were offered choices, spoken to respectfully, made to feel involved and all appeared content. Documentation is in place within the main care plan on how to care for people but the information contained is not always produced in a person centred format which makes the care plans hard to comprehend.

People living in Walnut house are involved in regular house meetings in order to ensure they have involvement in the service being provided.

Our judgement
People are treated with dignity and respect. They are involved in decisions about their day to day lives.

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

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Everyone living within Walnut house was able to communicate their views and were very positive about the service they receive. One person stated that they were "Very happy with the staff that support them and that they are always kind and listen to me." Another person, who was cooking at the time that we visited. They were very proud of their home and they told us that they "enjoyed cooking and going out."

Other evidence
We looked at the care records for two people during our visit on 08 November 2011 and these records showed that each person has a plan of care. Care plans we looked at recorded people's care needs and how these were to be met by staff. The care plan did not always provide specific guidance for staff as to what to do in order to ensure the person's wellbeing was maintained.

Risk assessments were not completed for all areas of assessed risk within those care files looked at. Where risk assessments were in place, further improvement were required to ensure that this clearly records the exact risk posed to the person and the steps as to how this is to be minimised. One example of this where a person was at risk from suffering epileptic fits.

In general terms daily care records were seen to be of a reasonable standard as they provided some insight as to how people spend their day and the care that people had received. During the visit we were able to directly observe the quality of care experienced by people living in Whitstone and Walnut house. This showed us that

people's general level of wellbeing was good and that staff interactions were positive. Some people were seen to be selfassured and confident, to make independent choices and decisions and to show signs of self respect and positive self esteem. Staff were seen to be kind and caring in their approach, to listen effectively and to respond appropriately.

We spoke with four members of staff on duty and all had good understanding of the needs of people, including triggers of behaviours.

The manager stated that the current staffing levels were adequate to meet the needs of people living within both houses. Several people living within Whitstone house are supported on one to one staffing levels and with some people requiring two to one support when accessing the community.

Staff described a range of activities that people are involved with and we saw the activity plans and also the daily notes that confirmed the activities that took place. People attend both daycentres and a study centre within the local area and others are provided with daytime activities by support workers.

Our judgement
People have a plan of care but some are incomplete whereby records do not always identify individual risk.This means that people may not be always be consistently receiving the care they need.

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
The majority of people living within Whitstone house were unable to communicate their views verbally with regard to safety and safeguarding. However one person spoken to said that they "Liked the staff and that they were kind." Three people spoken to in Walnut house all felt that staff "Were kind," caring and that they felt safe". One person said that if they had a problem they would "Go to the staff and report it."

Other evidence
Staff spoke to in both houses showed that they had a good understanding of safeguarding procedures and confirmed that they had received safeguarding training within the past twelve months. Training records received confirmed this. Staff knew where to find further information and contact details if they wished to report any concerns. Staff also understood about whistleblowing and about their responsibility to report any concerns. The staff that we spoke to felt that people living in both Whitstone and Walnut house received a good standard of care.

Our judgement
People living in the home are sufficiently protected due to effective systems in place for the reporting and recording of safeguarding.

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

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to people about this outcome.

Other evidence
Six staff we spoke to were able to confirm that they had recently received training in person centered planning, ethical control and restraint training, safeguarding, basic autism and emergency first aid at work. A copy of the training records was sent to us after the visit took place but these could not evidence that all staff have received the mandatory training required to carry out their role effectively.

The last fire training recorded was in 2010 with most staff recorded having completed this in 2008. Health and safety training was last carried out in 2010. One person completed this training in 2010 and the other two people completed this training in 2006 and 2007. Only one person is recorded as having completed infection control training. There was only five people recorded as having completed mental capacity act training and no records for the deprivation of libery safeguards training.

One member of staff we spoke to confirmed that their induction had been good and covered what they needed to know. We were told that the initial induction training undertaken in house covered all important core areas such as care planning and recording, safeguarding and risk assessing.

Six staff spoken to all confirmed that they receive supervision every two months and feel this process is both supportive and valuable. Staff meeting are also held every two months with the most recent being held in July and August.

The home has a homely and friendly atmosphere and observations confirmed that staff are providing a supportive and caring environment that can, at times be very challenging.

Our judgement
There is a lack of evidence to confirm that all staff are provided with the necessary training to carry out their role effectively.

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

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People living within Whitstone house were limited in being able to communicate their views in relation to this outcome but people living in Walnut house were able to confirm that they have regular service user meetings with one person stating that they "Like meetings with their friends and the staff."

Other evidence
The last service user meetings in Walnut house were held in June and August 2011 and
records were seen to evidence that these meetings had taken place. Service user meetings in Whitstone house are currently not held.

The manager explained the current systems for quality monitoring includes a monthly visit from the area manager covering a variety of areas including health and safety, care planning, staff training and the environment. However the system for monitoring and reviewing individual risk assessments and policies and procedures require improving as records seen during this visit were incomplete or out of date. Several policies including the safeguarding policy and the equal opportunities policy do not make any reference to current legislation.The staff handbook seen was dated 2008. The control of substances that may be hazardous data sheets were dated 2007.

Staff were not aware of any questionnaires being sent out to staff, carers and outside professionals. Staff stated that, "The majority of service users would be unable to complete a questionnaire." However it is important that people using the service are

consulted and involved in the care that they receive. There was currently no documentation available to confirm that surveys are given to people using the service and that this information is collated and acted upon.

Staff spoken with stated that they receive formal supervisions and attend regular staff meeting.

Our judgement
Quality assurance and monitoring is not yet fully developed in order to monitor and improve outcomes for people who use the service.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: Quality assurance and monitoring is not yet fully developed in order to monitor and improve outcomes for people who use the service.	

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.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People have a plan of care but some are incomplete whereby records do not always identify individual risk. This means that people may not be always be consistently receiving the care they need.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: There was inadequate evidence to confirm that all staff are provided with the necessary training to carry out their role effectively.	

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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