Review of compliance

Norman Laud Association Emscote House Adult Residential Services	
Region:	West Midlands
Location address:	Emscote House Emscote Drive, Wylde Green Sutton Coldfield West Midlands B73 5NE
Type of service:	Care home service without nursing
Date of Publication:	March 2012
Overview of the service:	Emscote House provides accommodation with personal care for up to eight people on a short stay basis. It does not provide nursing care.

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

Our current overall judgement

Emscote House Adult Residential Services 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 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 February 2012, observed how people were being cared for, looked at records of people who use services and talked to staff.

What people told us

When we visited the service on 1 February 2012 the registered manager told us that eight people were staying for a short break at that time. Seven people were out for the day as was their usual routine when they were at their family home.

We followed the care of one young person who was at the service that day including during the day. The manager told us that the person stayed regularly at the service. We saw they had the support of a care worker. We spoke to the person and had lunch with them. We saw that before lunch they had been out to local shopping centre with their support worker. They were actively engaged in computer and craft activities after lunch. We saw and heard that support workers helped them to make choices about food, drink and activity. They were helped to prepare their own lunch.

We saw that they had well organised and up to date care records. These included care plans that were individual to them. Risks posed to the person by their condition were identified and there were agreed plans for managing them. Plans and guidance for support workers balanced the person's safety with their right to take risks and enjoy independence.

We spoke to a worker who was on duty that day supporting the person whose care we followed. They knew the person well and were able to talk to us about the plan for their care and how risks were managed.
We looked at the training records of the keyworker to the person whose care we followed. We saw that they held the NVQ in health and social care at level three. They had also undertaken regular short training courses while in the employment of the provider

organisation. These included training in safeguarding adults from abuse and the risk of abuse.
We saw that the person whose care we followed had their own bedroom. It was clean and held sufficient furniture for comfort for a short stay at the service. The bathroom that they shared with other people was being refurbished while we were there.

We looked around the communal rooms at the service including the open plan kitchen used by people. These facilities were not sufficiently clean to protect people from the risk of infection. We have asked the provider organisation to improve hygiene practice at the service.

The manager told us that the basic staffing level at the service was one worker to two people. If a person required two workers support for their safety and care this level was provided when they stayed at the service. The manager said that there was a duty manager designated to run each shift. There were at least two workers awake on duty each night.
This level of staffing was confirmed by a support worker that we spoke to on the day of our visit. We saw that day that the person whose care we followed had one to one support from workers. We asked the person if they enjoyed staying at the service. They told us " it's alright- a bit noisy sometimes." We asked if the support workers were alright and they told us "yeah."

What we found about the standards we reviewed and how well Emscote House Adult Residential Services was meeting them

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

People who use the service experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. The service would improve if risk of infection in the environment was monitored and managed by more effective systems and policy and practice for hand hygiene was reviewed.

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

People who use the service are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

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

People who use the service are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

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

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

Our findings

What people who use the service experienced and told us
When we visited the service on 1 February 2012 the registered manager told us that eight people were staying for a short break at that time. Seven people were out for the day as was their usual routine when they were at their family home.
We followed the care of one young person who was at the service that day including during the day. We saw they had the support of a care worker. We spoke to them and had lunch with them. They confirmed that they were staying at the service for a few days and stayed very regularly. We saw that before lunch they had been out to local shops with their support worker. They were actively engaged in computer and craft activities after lunch. We saw and heard that support workers helped them to make choices about food, drink and activity.

We asked the person if we could look at their care records and they agreed. We saw that they had well organised care records. There was up to date information about their personal care needs, communication and language, medication and leisure and education and continuing contact with family. Plans for care and support were centred on the person as an individual and how they liked to do things. They were not just a list of tasks for workers to carry out. We saw that the risks posed to the person's safety and well being by their condition were assessed. The agreed plan for managing each risk was also 'person centred' and balanced their safety with their right to take risks and develop independence. We saw that there was a review of the person's care needs undertaken last in November 2011 in response to a change in medication. We saw daily and nightly welfare records made for the duration of the persons stay at the service.

We spoke to a worker who was on duty that day supporting the person whose care we followed. They knew the person well and were able to talk to us about the plan for their care and how risks were managed.
We looked at the training records of the keyworker to the person whose care we followed. They were not on duty on the day of our visit. We saw that they held the NVQ in health and social care at level three. They had undertaken short training courses in person centred planning, equality and diversity and safe physical intervention in crisis. They had undertaken updated training each year on safe administration of medication.

We asked the person whose care we followed if we could see their bedroom. We saw that it was minimally furnished for a short stay. The room was clean and had what was necessary for comfort and contained some personal belongings. We saw that the adjacent shared bathroom was undergoing refurbishment while we were there.

We looked around the communal rooms and kitchen used that day by the person whose care we followed. We saw that these facilities were either not clean or had been ineffectively wiped including where food was stored and prepared. There was build up of grime from hands on door frames and light switches and plugs including in the kitchen. This suggests poor hand washing practice. We asked the manager about this. She told us that there was a cleaning schedule carried out by support workers and that windows including the inside glass were cleaned every month by the maintenance worker.
We have asked the provider organisation to review policy and practice for hand hygiene and the cleaning arrangements for shared space in the home. These spaces were used by a constantly changing group of eight young people at a time. The cleaning regime should to be improved for hygiene and prevention of infection.

We asked the young person whose care we followed if they enjoyed staying at the service. They told us " it's alright- a bit noisy sometimes." We asked if the workers were alright and they told us " yeah."

Other evidence

Our judgement
People who use the service experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. The service would improve if risk of infection in the environment was monitored and managed by more effective systems and policy and practice for hand hygiene was reviewed.

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
When we visited the service on 1 February 2012 we followed the care of one person. We spent three hours in the communal rooms of the home and saw that support workers treated the person with respect and kindness. Workers asked the person's opinions and helped them to make choices about food and drink and activities. We saw that the person went out with the support of a worker in the morning. They were free to use their bedroom or the communal rooms. Although the level of personal supervision was high for their safety, this was discrete when it needed to be. It was based on an agreed written risk management plan.

We looked around the home and saw that when people stayed they had their own bedrooms. We saw that some bedrooms had customised cushioning on hard surfaces, including walls. We asked the manager about this. She told us that some of the people who regularly use the service were very vulnerable to injury because of conditions that produced seizures.

We saw that there were three communal rooms in the home and a garden. People were able to get away from each other if they wished to. The kitchen was open plan between two communal areas. People were not excluded from it visually even if it was not a safe space for them to be in physically.

We looked at the care file of the person whose care we followed. We saw written risk assessments and agreed management plans in place. There was clear guidance for workers in ways to avoid escalation of behaviour that could lead to distress or a crisis.

We looked at the training file of the keyworker to the person whose care we followed. We saw that they had undertaken training during 2011 in safeguarding people from the risk of abuse.
We talked to a support worker on duty on the day that we visited. They were aware of the provider organisation's policy and procedure on safeguarding people. They were able to describe their responsibility and the action they should take within their role.

Other evidence

Our judgement
People who use the service are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
When we visited the service on 1 February 2012 we were told by the manager that the home was full with eight people between the ages of eighteen and thirty. They were each staying for a short time of varying length. When they stayed at the service people pursued the usual day time arrangements that they followed at their own home. Seven people were out at day services or college that day.

We asked about staffing level. The manager told us that the basic staffing level was one worker to two people. Some people required two workers support for their safety and care. This level was provided when they stayed at the service. The manager said that there was a duty manager designated to run each shift. There were at least two workers awake on duty each night.
The manager was registered with us, worked office hours and was supported by a deputy manager who worked a mixture of office hours and shifts.

We saw that there was one person at the service during the day that we visited. They had a worker to support them continually including going out shopping with them. The manager was on duty and so was the deputy manager that day. We spoke to a support worker on duty about staffing level at the service. They confirmed that the roster was consistently managed.

The worker that we spoke to that day confirmed that they held the diploma in health and social care at level three. We saw from the training file of the keyworker to the person whose care we followed that they held the NVQ in health and social care at level three.

Other evidence

Our judgement
People who use the service are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

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 who use the service experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights. The service would improve if risk of infection in the environment was monitored and managed by more effective systems and policy and practice for hand hygiene was reviewed.	

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
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