

# Review of compliance

Mrs Philomena Chikwendu Okoron-Kwo Fouracres Care Services	
<b>Region:</b>	London
<b>Location address:</b>	47 Fouracres Enfield Middlesex EN3 5DR
<b>Type of service:</b>	Care home service without nursing
<b>Date of Publication:</b>	September 2011
<b>Overview of the service:</b>	<p>Fouracres is a small home registered to provide a service to four adults who have a learning disability. Ms Philomena Chickwendu Okoron-Kwo owns the service. A manager has recently been appointed. She has applied to the Commission to be the registered manager for the service.</p> <p>The home is located close to shops and public transport links.</p>

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

## Our current overall judgement

**Fouracres Care 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.

### What people told us

People were treated well by staff. We saw that staff understood their needs. People may not be safe and might be at risk of being abused as staff had not received up-to-date safeguarding training.

We observed that people were involved and consulted about decisions affecting their care.

### What we found about the standards we reviewed and how well Fouracres Care Services 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 could choose how they wished to be cared for. Staff listened to, and responded to their needs effectively. Overall, we found that Fouracres Care Service was meeting this essential standard.

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

People had a say in how they received care. People could be confident that staff knew how to meet their individual needs. Overall, we found that Fouracres Care Service was meeting this essential standard.

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

People felt safe and could raise concerns with the home. However, staff had not received refresher training on safeguarding. People may not be safe and might be at risk of being abused. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People felt that staff knew how to meet their needs. However, staff may not have all the skills needed to support people effectively. People may not receive the care and support they need. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

The service was not regularly assessing and monitoring what it is doing, so people may not consistently receive the care and support they need. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 28 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. Any regulatory decision that CQC takes 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 observed that people were involved and consulted about decisions affecting their care. Staff knew how to communicate with them. Staff took the time to make sure that they involved people in decisions about their care. Staff were seen to be knocking on bedroom doors. People were being supported to engage in activities in the local community.

#### Other evidence

There were activities planned for each person. Risk assessments and care plans showed what support people needed when engaging with their activities. People needed one-to-one staff support when engaging in activities outside of the home. People had signed their care plans. Their views were recorded in one-to-one meetings, and when their care plans were reviewed. Staff explained that regular key worker discussions were used to help people be involved in decisions about their care.

#### Our judgement

People could choose how they wished to be cared for. Staff listened to, and responded to their needs effectively. Overall, we found that Fouracres Care Service 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 were treated well by staff. We saw that staff understood their needs. They were treated respectfully and spoken to in an appropriate manner. People said that they received the care and support they needed. They had been involved in the care planning process and had taken part in reviews. Changes to their needs were discussed with them.

##### Other evidence

We looked at a number of care plans. These provided information about people's needs regarding their learning disabilities. Care plans gave clear guidance for staff about how they should meet people's learning disability needs. Staff understood people's needs. A pictorial format has been used so that people could be involved and their choices reflected in their care plans. Care plans showed the individuals' likes and dislikes. There were risk assessments in place to ensure that people's safety and well-being was maintained when receiving care.

Clear guidance was available in people's care plans regarding their need for one-to-one support. Daily notes showed that people were taking part in activities. Where they had particular behavioural needs these had been monitored regularly. Where necessary the appropriate professionals had been consulted for advice regarding people's behaviour.

##### Our judgement

People had a say in how they received care. People could be confident that staff knew how to meet their individual needs.

Overall, we found that Fouracres Care Service 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

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

#### Our findings

##### What people who use the service experienced and told us

People spoken to confirmed that they trusted staff and felt safe. They could discuss their concerns with the staff. They had information about what to do if they had concerns about the way they were being treated. Staff spoke to people in a manner that showed respect. People knew how to raise concerns about issues that affected their well-being.

##### Other evidence

Staff knew how to respond to safeguarding concerns to keep people safe and promote their rights. Staff knew how to recognise the signs of abuse. They knew who to report their concerns to. However, training records showed that staff had not received training on safeguarding in the last two years. They had not been trained in the local authority's safeguarding procedures. This means that people may not be safe and might be at risk of being abused.

People's care plans and assessments explained how each person's behaviour should be responded to. Staff knew how to respond to people's behaviour. Training records showed that the majority of staff had completed training on this area. People's behaviour was responded to in a way that made sure they were safe.

##### Our judgement

People felt safe and could raise concerns with the home. However, staff had not received refresher training on safeguarding. People may not be safe and might be at

risk of being abused. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

## 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 minor concerns with Outcome 14: Supporting staff

#### Our findings

##### What people who use the service experienced and told us

People felt that staff knew how to meet their needs. We saw that staff understood people's needs. Staff knew how to support them.

##### Other evidence

Staff told us they had received all their mandatory training, for example, moving and handling, medication, food hygiene and infection control. However, training certificates showed that most training had occurred over two years ago. We asked the registered manager about her training plans. She was not able to show us a training plan to confirm that staff would get the necessary training to ensure they could continue to meet people's needs. There was no information to show that any updated training had taken place or was being planned. The registered manager agreed to put a plan in place to make sure that staff receive the training they needed to meet the needs of people.

All staff felt that they had been supervised, guided and supported in their work with people. There were records of supervision available. These records showed that staff were receiving supervision regularly. Staff felt that supervision gave them an opportunity to discuss issues about how they care for people. Staff were supported to provide the care that people need.

##### Our judgement

People felt that staff knew how to meet their needs. However, staff may not have all the skills needed to support people effectively. People may not receive the care and support they need. Overall, we found that Fouracres Care Service was meeting this

essential standard but, to maintain this, we suggested that some improvements were made.

## 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

On this occasion we did not speak to people about this outcome area.

##### Other evidence

The registered manager explained that she spoke with people's relatives regularly to get feedback on the service. She said that a survey of people's views of the service had not been carried out recently. There were no records to show that the views of people who use the service, their relatives and relevant professionals had been sought.

We found that there were a number of areas where the quality of the service provided had not been reviewed. For example, there were no records to show that medication audits were taking place. There was no monitoring of training to ensure that staff had the skills to meet the needs of people. The service was not regularly assessing and monitoring what it is doing, so people may not consistently receive the care and support they need.

##### Our judgement

The service was not regularly assessing and monitoring what it is doing, so people may not consistently receive the care and support they need. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

## 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 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	<p><b>Why we have concerns:</b> People felt safe and could raise concerns with the home. However, staff had not received refresher training on safeguarding. People may not be safe and might be at risk of being abused. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.</p>	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	<p><b>Why we have concerns:</b> People felt that staff knew how to meet their needs. However, staff may not have all the skills needed to support people effectively. People may not receive the care and support they need. Overall, we found that Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.</p>	
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
	<p><b>Why we have concerns:</b> The home was not regularly assessing and monitoring what it is doing, so people may not consistently receive the care and support they need. Overall, we found that</p>	

	Fouracres Care Service was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
--	--

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 within 28 days of this report being received.

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

<b>Document purpose</b>	Review of compliance report
<b>Author</b>	Care Quality Commission
<b>Audience</b>	The general public
<b>Further copies from</b>	03000 616161 / <a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
<b>Copyright</b>	Copyright © (2010) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.

## Care Quality Commission

<b>Website</b>	<a href="http://www.cqc.org.uk">www.cqc.org.uk</a>
<b>Telephone</b>	03000 616161
<b>Email address</b>	<a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a>
<b>Postal address</b>	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA