

Review of compliance

Searchlight Workshops Powell House	
Region:	South East
Location address:	Claremont Road Mount Pleasant Newhaven East Sussex BN9 0NQ
Type of service:	Care home service without nursing
Date of Publication:	December 2011
Overview of the service:	<p>Powell House is one of three homes within the Searchlight Workshops organisation with places for up to sixteen people with a physical disability and who may also have a mild learning disability.</p> <p>All bedrooms are for single occupancy and are located over two floors. None of the bedrooms are provided with en-suite facilities. There are communal areas</p>

	<p>provided on the first floor. A passenger shaft lift is available for people who are unable to move independently between floors.</p>
--	---

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

Our current overall judgement

Powell 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 to check whether Powell House had made improvements in relation to:

Outcome 12 - Requirements relating to workers
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 30 September 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and reviewed information from stakeholders.

What people told us

People who use this service made no specific comments about the outcomes reviewed during this visit.

What we found about the standards we reviewed and how well Powell House was meeting them

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

Staff providing care to people had been checked for their suitability to carry out their role. There were recruitment policies and procedures in place.

On the basis of the evidence provided we found the service to be compliant with this outcome.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

Robust systems were not in place to ensure that the CQC received notifications as required.

Overall, we found that improvements were needed for this essential standard.

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 12: Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

People who use this service made no specific comments about this outcome.

Other evidence

During our visit we sampled the recruitment records for three recently appointed members of staff to work for the organisation, and found that arrangements were in place to ensure staff were safe to work with people living in the home.

We found that the required checks, including two satisfactory references, proof of identity and satisfactory Criminal Record Bureau (CRB) disclosures and Independent Safeguarding Authority (ISA) checks had been obtained for staff before they began work in the home.

One new member of staff recruited to work for the organisation was able to confirm the recruitment process was followed for them and that a representative for the people living in the service had also been involved in the recruitment process.

Our judgement

Staff providing care to people had been checked for their suitability to carry out their role. There were recruitment policies and procedures in place.

On the basis of the evidence provided we found the service to be compliant with this outcome.

Outcome 20: Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:

* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are moderate concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us

People who use this service made no specific comments about this outcome.

Other evidence

Although we had been informed that systems were now in place to ensure notifications are sent as required, information received as part of this review again evidenced that the Care Quality Commission has not received all the information of incidents in the home, or of important events that affect the welfare, health and safety of people who live in the service.

Our judgement

Robust systems were not in place to ensure that the CQC received notifications as required.

Overall, we found that improvements were needed for this essential standard.

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 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	How the regulation is not being met: Robust systems were not in place to ensure that the CQC received notifications as required. Overall, we found that improvements were needed for this essential standard.	

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	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

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA