Review of compliance

TRU Limited TRU ABI Rehabilitation Centre	
Region:	North West
Location address:	200 Ashton Road Newton Le Willows Merseyside WA12 0HW
Type of service:	Care home service with nursing Rehabilitation services Residential substance misuse treatment and/or rehabilitation service
Date of Publication:	August 2012
Overview of the service:	TRU ABI Provides support and care to people who have an acquired brain injury.The service is situated in a semi rural setting between Liverpool and Manchester with easy access to public transport and close to the motorway system.

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

Our current overall judgement

TRU ABI Rehabilitation Centre was not meeting one or more essential standards. Action is 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 11 July 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with people living at the home but their feedback did not relate to these outcomes.
We observed coaches, nurses and other members of the staff team engaging with people in a positive way.

What we found about the standards we reviewed and how well TRU ABI Rehabilitation Centre was meeting them

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

The provider was meeting this standard.
People experienced care, treatment and support that met their needs and protected their rights.

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

The provider was not meeting this standard.

Restraint of a person who required treatment on a regular basis was not undertaken within the MHA code of practice (1983). The person was not consulted before the restraint was applied to establish if they consented to the treatment without restraint and there was no

information recorded to demonstrate that the act of restraint had been reviewed on each occasion with the person.

We judged that this had a minor impact on people using the service.

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

The provider was meeting this standard.
Staff received appropriate professional development.

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 provider was meeting this standard.
There was evidence that learning from incidents / investigations took place and appropriate changes were implemented

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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

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 spoke with people living at the home but their feedback did not relate to this outcome.

One person observed was clearly agitated on occasions. We saw that staff responded well and seemed aware of their care needs.

We observed staff members interacting with people using the service. We saw people being offered choices and encouraged to participate in daily activities.

Other evidence
The Mental Health Act Commissioner carried out three monitoring visits to TRU ABI over the last eight months. Care Quality Commission (CQC) have a responsibility to monitor the provision of care and support to people who are detained under the Mental Health Act 1983 (MHA). Commissioners carried out the visits to the Newton unit at TRU ABI. This is the unit where people live who are detained under the MHA.

The commissioner had found ongoing concerns during these visits. During their last visit the commissioner identified a concern relating to the care plans of people who had been detained under the Mental Health Act 1983 (MHA).

A Mental Act commissioner and a compliance inspector from the Care Quality Commission (CQC) carried out this joint site inspection on the 11 July 2012.

During this inspection we looked at the care plans for the people living in the three units. On the day of the visit there were three detained patients and one informal patient living in the Newton Unit. Four people were living in the Lowton Unit and three people were living in the Willows Unit. A total of 11 people were living at TRU ABI.

The commissioner looked at the care plans for the three people who had been detained under the MHA and the compliance inspector checked the care plans for seven people, who were not detained under the MHA.

A separate monitoring report has been completed by the commissioner. This report will be sent to the provider.

The commissioner's report said, 'Care planning – the standard of care planning has improved with the care planning documents appearing to be more patient centred'.

We found that all of the care plans we looked at had been written in a person centred manner. This means that the individualised care plans focused on the person's individual assessed needs and on how they could be met. The care plans focused on providing support to an individual in different aspects of their daily life.

Some peoples' care files from the Willow Unit and the Lowton Unit were disorganised and two contained loose pages with sensitive information. This was brought to the attention of management and an assurance was given that all the files of people living at TRU ABI would be audited and reviewed, in order to ensure that they are secure and confidential.

During our visit we spoke with different members of staff including, coaches (support workers), nurses, an assistant psychologist, the clinical lead and the manager of TRU ABI

We spoke to members of staff about peoples' care plans and they were aware of individuals' care plans and of their assessed needs.

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected 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 non-compliant with Outcome 07: Safeguarding people who use services from abuse. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
During our visit we were informed that one person was being given an injection. There was documented evidence that this injected medication is given fortnightly. We were told that some restraint by staff was needed to administer the medication.
We were advised that this was a regular event. Incident forms indicated this pattern of behaviour was evident over the previous seven months.
The persons care plan did indicate that the medication should be given in this manner.

Other evidence
We looked to see if the person who was receiving the injection was asked before initiating the restraint if they would accept the injection without restraint. We checked the persons care records and there was no evidence to show that the person had been spoken to prior to this treatment or had been invited to accept the medication without restraint.

The Mental Health Act Code of Practice (1983) provides guidance to registered medical practitioners ("doctors"), approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking duties under the Mental Health Act. It also gives guidance to doctors and other professionals about certain aspects of medical treatment for mental disorder more generally.

We viewed care records to see if people had completed an advance directive (A

document regarding, whether a person had given previous permission or not to receive this medication). We were unable to find such evidence. There was also no evidence to show that a person had been invited to record their account of the episode of restraint, or were asked to consider the reasons for it. The Code of Practice, states, 'Patients should be encouraged to review their wishes with staff from time to time, and any changes should be recorded'. In discussion with the manager they agreed that the process of administering a persons injection, would be reviewed and they would ensure that people would be supported to consider and record the treatment and care.

We spoke to some members of staff regarding their understanding of safeguarding issues and how to respond to any allegation of abuse.

Staff were fully aware of the safeguarding process and had received safeguarding training. We checked the training matrix and it demonstrated that people are appropriately trained in the protection of vulnerable adults.

Following our inspection we were informed by the Local Authority's safeguarding team of a serious incident at another of TRU's services. This resulted in one person being transferred toTRU ABI. We were not informed of this during our visit.
Subsequently we have been informed by the manager that the person is receiving one to one support 24 hrs a day, which helps to ensure that the person and others are protected and safeguarded from harm or abuse.

Our judgement
The provider was not meeting this standard.

Restraint of a person who required treatment on a regular basis was not undertaken within the MHA code of practice (1983). The person was not consulted before the restraint was applied to establish if they consented to the treatment without restraint and there was no information recorded to demonstrate that the act of restraint had been reviewed on each occasion with the person.

We judged that this had a minor impact on people using the service.

Outcome 14:
Supporting 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 competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
We observed coaches, nurses and other members of the staff team engaging with people in a positive way.

Other evidence
The service has been in operation since springtime 2011. At this visit to TRU ABI we checked staff files and we saw that the files were well organised containing appropriate and relevant information with evidence of training being provided. There was a staff training programme in place showing evidence of mandatory training that had been provided. Other training that had been provided was de-escalation and breakaway, medication, infection control, Mental Capacity Act (MCA) and Deprivation of Liberties (DoLS). We were informed that the majority of training was provided within the organisation. One member of staff said, "I am learning an awful lot. I have just completed my National Vocational Qualification (NVQ) at level 3" another person said, "The training is really good".

We saw records that regular supervisions had taken place. One person said, "We have weekly supervisions with our manager".

The staff we spoke to during our visit, said that they enjoyed working there and valued working as part of a good team. One person commented, "It's a new challenge working here, people are very vulnerable and it can be difficult at times, but the staff team are supportive of each other".

A newly appointed member of the management team said, "The staff are so dedicated,

it's like a breath of fresh air working here".

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Our judgement
The provider was meeting this standard.
Staff received appropriate professional development.

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 spoke with people living at the home but their feedback did not relate to this outcome.

Other evidence
We observed that TRU ABI had systems in place for the monitoring of the service, with regular health and safety check audits being carried out to ensure the home was safe to work and live in. Some of the other audit forms lacked some detail and were not up to date.

In discussion with management it was commented that they were aware of some shortfalls with the existing monitoring of quality within the service. The manager said "A more robust audit monitoring system was in the process of being finalised, which will replace the existing audits, to ensure that all areas are covered for regulation". This will incorporate amongst other things, health and safety, medication audits; care planning, care notes and restraint.

We saw documented evidence of an incident, which had potentially placed people in danger of harm. The provider had contacted the emergency services to ensure that peoples' health and safety was maintained. We were informed by the manager that actions have been taken to reduce further risks. We observed that risk assessments had been put in place and a person's care and support programme had been immediately reviewed.

There was evidence of weekly team meetings taking place, with copies of minutes from the meetings being available.

One of the senior coaches said, "We also have weekly multi disciplinary team meetings (MDT), which involves clinical, medical and support staff. They are every Friday without fail". We saw minutes from some of the meetings, which demonstrated that staff had the opportunity to meet as a group and were able to discuss any relevant issues. We were informed by an assistant psychologist that, "the Responsible Clinician (Psychiatrist) meets with clients on a weekly basis to complete a Multi Disciplinary Team pro-forma. This is then presented at the MDT meeting. There is also a weekly clients meeting where people are encouraged to contribute and voice their opinions".

The service had not received any complaints, although there was an understanding of the process needed to deal with any concerns or complaints received. We checked the homes complaints policy and procedures.

During our inspection we observed a staff handover between shifts. We saw that staff arriving on duty were informed of what had happened during the last shift. This helped to show that consistency and continuity with peoples' care and support was maintained.

The provider had positively responded to the previous monitoring action plan that had been provided by the Mental Health Act Commissioner.

The recent commissioner's monitoring report stated that, 'Risk assessments now appeared more detailed and person centred. We were, though, unable to find dates of completion or dates for reviews for risk assessments'. We were informed by the manager that the risk assessment process would also be part of the new 'robust' audit system.

CQC had recently received information form the Local Authority, regarding three safeguarding alerts they had received. CQC had not been notified by the provider of these safeguarding alerts or of the incidents relating to the alerts. The provider has the responsibility to notify the CQC about incidents that affect the health, safety and welfare of people who use services. Prior to our inspection we wrote to the provider informing them that they were not following the correct procedure.

We were informed by the provider that this was an error on their part and that it would be immediately addressed.

During our inspection the manager stated that, 'the letter sent by CQC had been forwarded to all of the TRU locations'.

The outstanding notifications had been sent to CQC before our inspection and since then we have received other notifications from the provider. This demonstrates that the organisation is now aware of their regulatory responsibility in providing notifications to the CQC.

Our judgement
The provider was meeting this standard.
There was evidence that learning from incidents / investigations took place and

appropriate changes were implemented

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 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Restraint of a person who required treatment on a regular basis was not undertaken within the MHA code of practice. The person was not consulted before the restraint was applied to establish if they consented to the treatment without restraint and there was no information recorded to demonstrate that the act of restraint had been reviewed on each occasion with the person.	
Accommodation for persons who require treatment for substance misuse	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Restraint of a person who required treatment on a regular basis was not undertaken within the MHA code of practice. The person was not consulted before the restraint was applied to establish if they consented to the treatment without restraint and there was no information recorded to demonstrate that the act of restraint had been reviewed on each occasion with the person.	
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 11 HSCA 2008 (Regulated	Outcome 07: Safeguarding people who use services from

	Activities) Regulations 2010	abuse
	How the regulation is not being met: Restraint of a person who required treatment on a regular basis was not undertaken within the MHA code of practice. The person was not consulted before the restraint was applied to establish if they consented to the treatment without restraint and there was no information recorded to demonstrate that the act of restraint had been reviewed on each occasion with the person.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Restraint of a person who required treatment on a regular basis was not undertaken within the MHA code of practice. The person was not consulted before the restraint was applied to establish if they consented to the treatment without restraint and there was no information recorded to demonstrate that the act of restraint had been reviewed on each occasion with the person.	

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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