

# Review of compliance

## Advance Housing and Support Limited Leicester Domiciliary Care Services

<b>Region:</b>	East Midlands
<b>Location address:</b>	94 New Walk Leicester Leicestershire LE1 7EA
<b>Type of service:</b>	Domiciliary care service
<b>Date of Publication:</b>	March 2012
<b>Overview of the service:</b>	<p>Leicester Domiciliary Care Services is owned and managed by Advance Housing and Support Limited. The service is located in Leicester and provides a service to people with a learning disability. It is registered to care for people under the following regulated activity:-</p> <p>Personal care</p>

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

## Our current overall judgement

**Leicester Domiciliary Care Services was meeting all the essential standards of quality and safety.**

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, 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 did not speak to people whose records we had viewed as we were unable to speak with them on the telephone or they were unable to give their permission for us to contact them.

We spoke with a relative of someone who used the service. They expressed satisfaction with the service provided and told us they along with the person using the service had been involved in decisions about the care and support provided.

### What we found about the standards we reviewed and how well Leicester Domiciliary 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 had been supported and encouraged to make decisions about their daily lives and had been provided with opportunities to influence the service they received.

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

People had the opportunity to influence the care and support they received which met their individual needs.

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

## **human rights**

People were supported by staff that had undergone training and who had a good understanding as to their role and responsibilities in protecting people from abuse.

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

People were supported and cared for by staff who had undergone a robust recruitment process which had included processes to determine their suitability to work with vulnerable adults.

### **Outcome 17: People should have their complaints listened to and acted on properly**

Systems were in place which enabled people to complain about the service they received.

## **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 did not speak to people whose records we had viewed as we were unable to speak with them on the telephone or they were unable to give their permission for us to contact them.

#### Other evidence

We looked at the providers' document which was entitled 'your SUPPORTFILE', the document informed people about the services provided and how the service considered people's rights, equality and diversity. The guide detailed how people's needs were assessed and the ongoing review process of people's needs.

We looked at the providers' document which was entitled 'Choosing Staff An easy read guide'. The document provided information to people who used the service about how they could be involved in the recruitment of staff.

We looked at the care plans and person centred plans of four people who used the service. Care plans and person centred plans had been developed using large print and included symbols and pictures to enable the person who used the service to have a better understanding of their care plan.

We spoke with staff that supported the people whose records we had viewed, they confirmed the person using the service and in some instances their relative had been involved when their care package had been reviewed.

**Our judgement**

People had been supported and encouraged to make decisions about their daily lives and had been provided with opportunities to influence the service they received.

## 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 did not speak to people whose records we had viewed as we were unable to speak with them on the telephone or they were unable to give their permission for us to contact them.

We spoke with a relative of someone whose records we had viewed and asked them for their views about the service provided. They told us their relative and they had been involved in the reviewing of the persons care package and that they were happy with the service provided. Care plans we viewed had been signed by the person using the service.

##### Other evidence

We looked at the care plans and person centred plans of four people who used the service. People's plans detailed the support provided to them which included, support with the preparation of meals, management of correspondence, financial management, accessing community resources, shopping and household chores. Records detailed which day's people received support, the type of support, and the time allocated. Comprehensive records were kept detailing the support people using the service had received on a daily basis.

We spoke with staff that supported people whose records we had reviewed and asked them for their views about the provider and the service it provided. They told us: - "I think Advance is really great, they totally fill a need in the community. If it wasn't for

them people couldn't live within the community, we've provided a real turn around for people in terms of quality of life. I am genuinely impressed with the organisation."  
"Service users get treated well."

Staff told us about the training they had received which enabled them to support people. Training which supported people's health and safety included first aid and food hygiene. Training also focused on topics related to people's health, care and welfare and had included managing challenging behaviour, epilepsy awareness, personal budgeting, and equality and diversity.

Staff we spoke with who supported the people whose records we had viewed confirmed the care and support they provided was consistent with information recorded within the persons' care plan and the review of a persons needs had involved the person using the service.

**Our judgement**

People had the opportunity to influence the care and support they received which met their individual needs.

## 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

We did not speak to people whose records we had viewed as we were unable to speak with them on the telephone or they were unable to give their permission for us to contact them.

We spoke with a relative of someone who used the service. They told us the service had made a safeguarding referral to the local authority when their relative had been a victim of identity theft. The relative said "advance dealt with it extremely well."

##### Other evidence

We looked at the providers' document which was entitled 'your SUPPORTFILE', the document provided information to people who used the service about abuse, and the types of abuse vulnerable people were at risk of. It included contact details for agencies for people to contact if they wished to report abuse and included contact information about advocacy services.

The records of one person using the service showed that the provider had made a safeguarding referral to Leicester City Council when they believed someone using the service had been put at risk through identify theft.

We spoke with staff who told us they had received training on the safeguarding of vulnerable adults and they were confident they would report any issues which suggested people were being abused.

**Our judgement**

People were supported by staff that had undergone training and who had a good understanding as to their role and responsibilities in protecting people from abuse.

## 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

The provider is compliant with Outcome 14: Supporting staff

#### Our findings

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

We did not speak to people whose records we had viewed as we were unable to speak with them on the telephone or they were unable to give their permission for us to contact them.

##### Other evidence

We looked at information held about three members of staff who worked at the service. We found that the provider had undertaken checks on staff to determine their suitability to work with vulnerable adults. A vulnerable adult is someone who is unable to protect themselves from significant harm or exploitation due to their health, age or disability. Checks that had been undertaken included a Criminal Record Bureau (CRB) disclosure, the seeking of two written references and proof of a prospective staff's identity

##### Our judgement

People were supported and cared for by staff who had undergone a robust recruitment process which had included processes to determine their suitability to work with vulnerable adults.

## Outcome 17: Complaints

### What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- \* Are sure that their comments and complaints are listened to and acted on effectively.
- \* Know that they will not be discriminated against for making a complaint.

### What we found

#### Our judgement

The provider is compliant with Outcome 17: Complaints

#### Our findings

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

We did not speak to people whose records we had viewed as we were unable to speak with them on the telephone or they were unable to give their permission for us to contact them.

The relative of someone who received the service told us they were aware of how to raise concerns.

##### Other evidence

We looked at the providers' document which was entitled 'your SUPPORTFILE', which provided information to people used the service about how to make a complaint if they were unhappy with the service they received.

The provider told us that the service had not received any complaints within the last 12 months. We had not received any information of concern about the service.

##### Our judgement

Systems were in place which enabled people to complain about the service they received.

# 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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