Review of compliance

Swanton Care and Community Limited Darwin Place	
Region:	West Midlands
Location address:	Southfield Road Much Wenlock Shropshire TF13 6AT
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	This service provides accommodation, care and support to up to four people with a learning disability. It is situated in the Shropshire town of Much Wenlock.

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

Our current overall judgement

Darwin Place 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, talked to staff and talked to people who use services.

What people told us

Most of the people who live in this home have difficulty in expressing their views verbally. However, those that could do told us that they were regularly involved in activities that they needed or enjoyed. During the visit we saw people going out accompanied by staff and some were able to tell us about a series of activities that they regularly take part in.
One of the people that we talked to told us that she was able to sit down with staff to discuss any issues she might have about the service she was being provided with. She also said that she felt that staff listened and changed her support package if necessary.
Some of the people who live in this home were able to tell us that they knew how to raise any issues that worried them with any member of staff and that they felt that their worries would be listened to. They also told us that they felt safe living in the home.

What we found about the standards we reviewed and how well Darwin Place 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

This service puts people at the centre of their care so that they can make decisions and understand the support available to them. People have their views taken into account and are encouraged to care for themselves and are involved in how the service is run.

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

People who live in this home have their needs assessed and care is delivered in a way

that focuses on their individual needs.

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

People receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur. Staff have the knowledge of how to protect people 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

The provider makes sure that there are sufficient staff with the right knowledge, experience, qualifications and skills to support people so that they are safe and their health and welfare needs are continually met.

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 monitors the quality of the service, investigates any poor practice and improves the service by learning from events so that people receive safe care.

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 talked with four of the staff and they showed good understanding of the issues involved in maintaining people's privacy and dignity and respecting the diversity and human rights of the people who live in the home. Throughout the visit we heard and saw the staff behaving in a way that confirmed that they put those principles into practice.
Examples of this were when we saw someone prompted discretely to change their clothes and in the way another person was talked to about their behaviour goals for the day.
We also saw how staff respected the wishes of people who wanted to stay in their rooms. Other people were heard talking with staff who explained to them what they could do that day and gave them a choice of activities that they were known to like.
We talked to one of the people who told us that she was able to sit down with staff to discuss any issues she might have about the service she was being provided with and she also said that she felt that staff listened and changed her support package if necessary.

Other evidence
A number of the people who live in this home have difficulty in verbally communicating their views. To establish that their needs were being met we interviewed staff and

looked at care records as well as observed people's reactions to the care that they were provided with on the day of the visit.
We looked at the records that the home kept for three of the people who live there. Each plan was written in a way that showed that the individual's communication difficulty was taken into account. It also showed how the person would communicate enthusiasm or reluctance as the home tried to meet their needs. Talking to staff established that they understood why this was necessary.
Staff also demonstrated an awareness of the processes that should be followed if someone's freedom need to be curtailed for their own safety. We discussed these issues with the manager who would have to apply to the local authority for approval in such cases and she also showed a good awareness of how and why such matters were necessary.

Our judgement
This service puts people at the centre of their care so that they can make decisions and understand the support available to them. People have their views taken into account and are encouraged to care for themselves and are involved in how the service is run.

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
The people who live in this home have varying abilities in communicating. From talking with and observing them it was clear that some of them could, with careful interaction by the carers, take part in discussions about their care. Others, however, could not and staff told us how they monitor the reactions of all of the people who live in the home to see how they react to any changes made in their care packages.
We spoke with some of the people and we asked them what they thought about the house, the staff, the meals and any activities that they were involved in. When necessary we rephrased the questions and people nodded, smiled or said yes or no in answer. All of those that could communicate were clear that they liked living there.
We also observed the people who live in the home throughout the visit.
We saw that they were happy with the meals that were served at lunch-time. One of the people who live in the home told us that each Thursday the group did their shopping at a local supermarket and after that they usually went for a meal at a restaurant. She told us that this was something she enjoyed.
We also saw that staff were talking with people but were also sensitive to those who clearly wanted more space to themselves.

Other evidence
During our visit we saw a range of documents that outlined the care and social needs of people living in the home and we saw that these had been looked at each month to check that no changes were necessary.
Person centred plans identified the needs and preferences of each person as well as the details of how those needs and preferences should be met. We also saw that

behaviour management plans had also been developed which identified how those who had little or no verbal or signing communication were making their views known.
During the visit we talked to the staff and they were all aware of the contents of the care plans of the people who live in the home. They also confirmed that they were involved in the individual reviews of peoples' care each month. Staff also told us that they have input when plans are due to be reviewed and communicate their opinion as to what's working and not working.
During the visit we saw that peoples person centred plans contained their likes and dislikes around food and activities. We talked to staff and they said that people could indicate clearly what their preferences were.
Staff also talked about how they had learned, over time, the preferences of the people who had more difficulty saying what their favourites were.

Our judgement
People who live in this home have their needs assessed and care is delivered in a way that focuses on 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
The people who live in this home have severe difficulties with communication. Some were able to answer some of our questions. One person was able to tell us who she would tell if anyone hurt or upset her.
We watched and listened to the staff as they worked with the people who live in the home. We saw that they were alert to the different ways that individuals showed different emotions such as enthusiasm and reluctance. Talking to various members of staff confirmed that they monitored peoples behaviour for signs of change that might indicate that they were unhappy and therefore potentially subject to abuse. We saw that these observations were recorded throughout the day.

Other evidence
We saw that a whistle blowing policy was available for the staff team to read and it was clear that the staff that we talked to were aware of what it contained.
When we talked to the staff they also told us that they had received training in the management of aggression. The method that they had been taught was one that is accepted as being appropriate throughout this care sector.
Staff also told us that they had received training in how issues of abuse should be managed. This training had been provided by the local authority ensuring that everyone was aware of the local policies and procedure for the protection of people at risk of harm.
The manager told us that one recent issue had been referred into those procedures. Feedback from the local authority, who is responsible for investigating such matters, indicated that the home had co-operated with them in a positive manner.

The manager also confirmed that none of the people living in the home were subject to any formal decisions that deprived them of any of their liberty under the Mental Capacity Act. When we talked she showed a good knowledge of her and the home's duties under that Act.
We also talked about how the money belonging to the people who live in the home was managed. The manager described a recording system that was transparent and easy to complete and explained that she checked those records for accuracy and her area manager could also check them as part of the monthly checks.

Our judgement
People receive a service from a provider who takes steps to prevent abuse and does not tolerate any abusive practice should it occur. Staff have the knowledge of how to protect people 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
Most of the people who live in this home have difficulty in expressing their views verbally however, those that could told us that they were able to regularly take part in the activities that they needed or enjoyed.
We saw that there are sufficient numbers of staff with the right competencies, knowledge, qualifications, skills and experience to meet the needs of people who use services at all times.
Staff told us that each person who lives in the home has a member of staff working exclusively with them during the day. We looked at the rota which confirmed this.
The manager told us and the staff confirmed that staffing levels were reviewed routinely as part of ongoing assessments of risks involved in the situations and activities, such as holidays, that had been identified in the past.

Other evidence
We looked at the staffing rotas, people's activity records and the staff training records to confirm what we had been told by the people who live in the home and the staff.

Our judgement
The provider makes sure that there are sufficient staff with the right knowledge, experience, qualifications and skills to support people so that they are safe and their health and welfare needs are continually met.

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
The people who live in this home have severe difficulties with communication. We did not discuss this outcome with them.

Other evidence
The manager and the staff told us that the owner of the home had visited regularly. We saw copies of written reports that confirmed this.
We also saw the records of audits on such things as health and safety, infection control, medication, skills development, physical wellbeing and empowerment. One of these areas had been chosen to be looked at each month across the provider's establishments so that any trends and issues could be identified at corporate level as well as in the individual homes and services.
We also saw that the weekly fire safety checks were also recorded.
We talked with the staff and they made it clear that they understood their part and the role of others in the running of the home. Throughout the visit we saw how staff who held different positions consulted with each other appropriately as issues came up and were resolved. They also told us that staff meetings are held regularly and we saw minutes of meetings that confirmed this.

Our judgement
The provider monitors the quality of the service, investigates any poor practice and improves the service by learning from events so that people receive safe care.

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	

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