Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Longton Court

8 Longton Grove Road, Weston-super-Mare, BS23 1LT

Tel: 01934708771

Date of Inspection: 11 February 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Community Therapeutic Services Limited
Registered Manager	Dr. David Bladon-Wing
Overview of the service	Longton Court provides accommodation for up to four adults with learning disabilities, autism spectrum disorder or other mental health conditions.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 February 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

There were four people living at the home at the time of the inspection. We met with three people and one person was able to tell us their views in detail. Most people were limited in their abilities to communicate verbally with us so we also observed the care provided to help us to understand their experience.

People we asked told us they liked living at the home, especially having access to the local community. One person told us "I like seeing staff and (people living at the home). I really like going out with staff". Care plans and risk assessments were person centred, regularly updated and implemented effectively to ensure each person's needs as an individual were met.

We observed staff asking for people's consent before they assisted them and where people lacked capacity, staff were skilled in working with them to make choices and worked in line with legal requirements.

People we asked told us they felt safe. Safeguarding procedures were in place and behaviour management plans were implemented to reduce the use of restraint to a minimum.

People told us they got on well with staff. One person told us "I sit down and talk to staff if I have a problem". We observed each person had access to at least one staff member who was assigned to them through the day to provide personalised care and support.

There was a robust quality monitoring system in place demonstrated particularly by the way incidents were analysed to ensure continual service development.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We observed staff asking for people's consent consistently throughout the day before they assisted and supported people. Staff were knowledgeable about how each individual expressed their agreement or displeasure about care and support and we observed staff responded to this and acted in accordance with people's wishes. Staff were confident that they had people's consent when they supported them because they used a variety of methods to offer choices to people and to record people's preferences over time. Staff told us about how they ensured they obtained consent from one person in the house who found choices overwhelming. We saw this being put into practice around the person's breakfast routine. People's care plans were detailed in relation to people's likes/dislikes and the specifics of the consent they had given and this informed staff's practice.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We saw a Deprivation of Liberty Safeguard (DOLS) report which detailed how one person's freedom had to be restricted in one specific way due to the potential risk of harm to themselves and others. Staff had applied for DOLS in line with legal requirements and were using the least restrictive measure in this case by trialling methods to resolve this situation. On the day we visited the home's Behaviour Management Advisor was there to offer support and advice with this situation.

In people's care files we saw references to capacity assessments that had taken place to assess people's capacity around making specific decisions, for example around consenting to medical tests and taking medication. Where this had happened, the relevant and appropriate professionals had been involved and 'best interests' meetings had taken place to decide what would be in the best interests of the person in each case.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

The two people we asked told us they liked living at Longton Court and people told us about the different aspects of the home and their support that they enjoyed. For example, one person told us "I like seeing staff and (other people living at the home)" and two people told us they enjoyed going out with staff to do the activities they chose to do. We observed staff giving positive feedback and reinforcement to people and we noted on one person's wall there were award certificates for the person 'having a good week' which were used as a way to encourage them. This meant that people were respected, given positive feedback and supported to do the things they wanted to do.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at three from four clinical files which included individual care plans and found the information to be detailed, person centred and informative about the person's needs. The care plans were done using 'person-centred planning' methods which aimed to put the person at the centre of their care. The care plans broke down each aspect of care into sections, for example, the person's mental health, sleep and personal hygiene and detailed the person's individual needs under each section which was clear to follow. We observed care being delivered as outlined in the care plans for the three people we met. For example, we observed staff supporting one person to access the local community with two staff members in line with the person's needs and using a specific method of transport. Dates on the care plans indicated that people's needs were regularly reviewed.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People's files were detailed and held up to date 'positive risk assessments' that analysed the potential risks in each situation but also reflected on the impact of limiting the person. We saw staff assessing risk in a variety of ways throughout the visit. Staff used handover times as 'briefings' and part of this time was dedicated to going through any recent incidents forms and reflecting on current risks in the home. A board in the home was used to display 'daily risks' as a way to keep staff up to date on people's current moods, behaviours and the potential risks these might present. We observed two staff supporting one person at certain times when there was the potential for their behaviour to escalate, in line with risk assessments, to ensure staff and people at the home were kept safe.

People's care and treatment reflected relevant research and guidance. On the day we visited we observed the staff handover or 'briefing' which included time devoted to 'bite size training'. One member of staff had done research around depression from a particular book, adapted it to relate to one of the individual's living at the home and delivered training to other staff about how to incorporate this guidance into the way staff supported the person.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. On the day we visited there was one staff member assigned to each individual within the home and we saw from the rota that this staffing ratio was in place every day throughout the week. This meant that each person had equal access to the same level of staff support and personalised care.

There were arrangements in place to deal with foreseeable emergencies. We saw a policy relating to 'dealing with accidents and emergencies' and staff told us how they had recently put this in place to ensure continuity of care in the recent adverse weather conditions. People's care files included emergency packs which summarised all the information provided in their care files and could be passed onto other providers or services if people needed emergency care.

The Deprivation of Liberty Safeguards were only used when it was considered to be in the person's best interest. Staff told us about circumstances when they had considered making an application under the Deprivation of Liberty Safeguards but they had worked with the person around their needs and the application had not been necessary. There was one Deprivation of Liberty Safeguard in place at the time of the inspection and staff were already introducing freedoms to the person around that aspect of care, in collaboration with the provider's Clinical Psychologist and Behaviour Management Specialist.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff told us that due to the mental health needs of the people at the home, there was the potential for incidents to happen between the people living there. Risks had been identified in people's needs and risk assessments and appropriate staffing levels and behaviour management plans were in place to ensure people were kept safe.

The provider responded appropriately to any allegation of abuse. We saw the safeguarding adults policy and found it to be detailed and relevant, listing contact numbers for the appropriate professionals to inform, should abuse be identified. Staff had all signed to say that they had read the local authority safeguarding policy and staff were knowledgeable about the different types of abuse, how they would identify it and their responsibilities in escalating a safeguarding concern. Staff told us that if they had a concern about the home that they were unable to raise under the home's own safeguarding procedures then they would contact the Care Quality Commission. We saw the training calendar which showed that all staff were booked to undertake 'care practice' training on 5 March 2013 which involved safeguarding refresher training. We saw minutes from safeguarding adults strategy meetings concerning people at the home which confirmed that concerns were passed on by staff to the appropriate professionals where abuse was suspected and concerns were dealt with in line with the safeguarding procedure.

People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. We saw the staff training matrix which showed that all staff had completed a refresher in physical restraint techniques in January 2013. Staff we spoke to confirmed this and all staff were knowledgeable about the interventions they used with people in the home to de-escalate behaviours. We observed staff using techniques as outlined in people's 'risk assessment and management plans' to ensure people could move safely around the home and people's wishes in relation to maintaining their preferred amount of personal space was respected. Staff told us that physical restraint was a last resort and that it was rarely used because staff used the management plans, which were developed by the Behaviour

Management Specialist, to follow individual protocols around de-escalation. Incident forms recorded where 'breakaway' or restraint techniques were used, the length of time and were signed by staff to ensure there was accountability in using the techniques.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

The people we spoke to at the home told us they got on well with staff. One person told us about what happens when there are staff absences. They told us "I really like going out with staff but it depends if they're short (on staff). A few days ago (keyworker) was off sick but (another worker) could take me out".

On the day we visited, one staff member had called in sick that morning. The shift leader found a replacement and a staff member who worked at one of the provider's other homes was able to cover this absence within fifteen minutes. We observed the staff member to be a suitable replacement because they had experience working with people with similar needs and were knowledgeable about the provider's procedures and policies. This meant that the home had an effective system in place to cover staff absences and ensured sufficient staffing levels were maintained.

We found the staff rota to be an accurate reflection of the staffing levels in the home at the time of inspection. We noted that seven staff were assigned to the home throughout the day. This meant that one staff member was assigned to each person to give one to one support and additional staff were available when the person needed two people to assist them.

One member of staff was assigned to provide support during the night with a second staff member assigned to sleep at the home but who could be called upon if additional assistance was required. The evidence we reviewed demonstrated that people using the service could be confident that they had access to their own personalised support throughout the day and assistance at night if this was required.

Staff told us about relevant experience they had prior to working at the home and we observed staff interactions with people to be skilled, sensitive and respectful. Staff were able to tell us about people's individual needs and we observed detailed staff discussion in the briefings between shifts which demonstrated staff's in depth knowledge of each person living at the home.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

There was a robust system in place for monitoring the quality of the service that people received at the home. We saw 'quality assurance' files for 2012 and 2013 that contained a report relating to a 'mock inspection' carried out by a manager external to the home, a service improvement plan for 2013 and reflection on reports relating to improving care. This demonstrated that quality was being monitored formally through a variety of methods.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw questionnaires that had been filled in by people living at the home, their relatives and other professionals which gave their views on the care provided. The responses were positive indicating that people were satisfied with the service and quality of care. We observed one person expressing their views about their activities planner and staff worked with the person to make amendments to their routine where this was requested. Notes in care files indicated that where people expressed their preferences or views about an aspect of care this was recorded and staff responded.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. The staffing arrangements in place meant that staff could call upon members of the management team for advice when needed. The management team included a full time Manager, Operations Manager, Behaviour Management Specialist and Clinical Psychologist who provided guidance and made decisions about care when escalated by staff.

For example, in relation to the Deprivation of Liberty Safeguard that was in place, there was evidence that there had been input from staff at the home and they had worked in collaboration with members of the management team to implement the DOLS and work towards reaching a resolution.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. On the day of the inspection the Behaviour Management Specialist attended the home in person to pick up the incidents forms for the

week. Staff told us that the incidents forms are then looked at by the management team who identify whether they needed to provide extra support for staff in the home or whether other measures were necessary. We saw charts that analysed the number and nature of incidents monthly and any patterns were identified by the manager to be acted upon. We saw incidents forms that had been completed by staff and included reflective accounts about how the incident might have been managed differently and how future incidents of a similar nature might be avoided. There was evidence that staff had reflected on incidents particularly with respect to the behaviour management plans in place for each individual and how they were implemented.

The provider took account of complaints and comments to improve the service. We saw the complaints procedure which was pictorial for ease of use by people living at the home and included the specific names of staff who handled complaints and timescales for getting a response. There was a complaints audit that had been completed by the manager and identified that one complaint had been made over the last year. We were unable to see the complaint form this related to at the time of inspection as the form had been archived.

Staff told us about a complaint they had received in the past by one person about noise being made by another person in the home. Staff were knowledgeable about the process and how they supported the person to make the complaint. The one person we asked told us they felt able to raise any complaints or concerns with staff. They told us "I go to (staff member) and let them know if I have a problem...I can talk to someone else if my keyworker's off sick".

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – 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.

Moderate impact – 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.

Major impact – 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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