Review of compliance

Active Support Service Limited Alex House	
Region:	East Midlands
Location address:	7 Alexandra Street Kettering Northamptonshire NN16 0SX
Type of service:	Domiciliary care service Supported living service
Date of Publication:	January 2012
Overview of the service:	Active Support Service is a domiciliary care service based in Kettering. It provides a range of personal care and support to about 60 people living in their own homes in Northamptonshire. People can access the services through a referral from the local authority or by going directly to the agency. More information about the service can be found in the statement of purpose

	available from the provider.

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

Our current overall judgement

Alex House was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 November 2011, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke with four people who told us that they were happy with the service they received from Active Support. One person told us that they had made many friends through the support that they received from Active Support.

People spoke highly of the staff saying they arrived on time or telephoned if they were delayed. Two people explained that the staff spent enough time with them to do the things they needed support with without having to rush.

We spoke to the relative of someone who receives a service from Active Support. They told us that they were happy with the care that their family member received.

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

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

Plans of care did not provide adequate detail to ensure people's individual care needs were 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

There were systems in place to monitor quality and to act on feedback from people who use the service and their representatives. These systems did not always identify problems with care planning.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 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

There are minor concerns 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 four people who told us that they were happy with the service they received from Active Support. One person told us that they had made many friends through the support that they received from Active Support.

People spoke highly of the staff saying they arrived on time or telephoned if they were delayed. Two people explained that the staff spent enough time with them to do the things they needed support with without having to rush.

We spoke to the relative of someone who receives a service from Active Support. They told us that they were happy with the care that their family member received.

Other evidence
Each person who receives a service from Active Support had a file containing their assessments and care plans. We looked at five care plan files, all of which contained basic information to help staff care for people in the right way.

We spoke to three members of staff. They told us that they were always introduced in person to people they were going to support to make sure that people were not supported by someone that they do not know. Staff explained that people received a schedule that tells them who will be supporting them for the following month. Staff told us that they were given enough time with each person to give them the care and support that they needed.

Care plans contained some basic information about people's needs but did not give details about how staff needed to support people. For example, a care plan for one person stated that they needed support with road safety but did not detail how staff should support them; the care plan for another person said that they needed reminding about their personal care but did not state how or when they usually carry out their personal care routines.

We saw that care records for another person were contradictory about how the person should be supported when they become anxious. In one part of the person's care records it stated that talking about the person's worries helped reduce their anxiety. In another part of the care records it said that staff should "steer the conversation away" from the person's worries and try to change to subject.

We looked at the care records for one person who had diabetes. There were no details in her care plan about how staff should support this person to manage their diabetes. We saw that another person has some picture cards in their care records to assist them with communication. There were no details in this person's care plan to say how they communicate with other people. This meant that staff did not have the information that they need to support the person in the right way.

We discussed these issues with the manager during our visit to the service. The day after our visit the manager told us that she had revised the format of people's care plans following our discussions to include more detail about the support people need.

Our judgement
Plans of care did not provide adequate detail to ensure people's individual care needs were 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

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not discuss this outcome area with any of the people who receive a service from Active Support.

Other evidence
We looked at the results of satisfaction surveys which people who use Active Support had completed in February 2011. They showed a good level of satisfaction. The manager told us that she had updated the format of the satisfaction surveys to make them easier for people to complete. We saw that pictures and symbols had been used to help people with limited reading skills.

We saw the records of telephone calls made to people who use Active Support to check if they were happy with the support that they receive. We also saw records of visits that had been made to people to ask them for feedback about the service that they receive. The manager told us that the system for carrying out these telephone checks and visits had recently been revised. She explained that this was so checks happened more frequently and to make sure that the visit included checking the person's care plans.

We discussed the issues that we found with people's care plans with the manager during our visit to the service. The day after our visit the manager told us that she had revised the format of people's care plans following our discussions to include more detail about the support people need.

Our judgement
There were systems in place to monitor quality and to act on feedback from people who use the service and their representatives. These systems did not always identify problems with care planning.

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
Personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Plans of care did not provide adequate detail to ensure people's individual care needs were met.	
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There were systems in place to monitor quality and to act on feedback from people who use the service and their representatives. These systems did not always identify problems with care planning.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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