Review of compliance

Arventa Care Limited Kingsley Court	
Region:	East
Location address:	77 The Causeway Potters Bar Hertfordshire EN6 5HL
Type of service:	Care home service without nursing
Date of Publication:	September 2011
Overview of the service:	Arventa Care Limited is registered to provide accommodation at Kingsley Court for up to 15 people. The service is set up to support people with a diagnosis of Autism or Asperger's syndrome. The service does not provide nursing care.

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

Our current overall judgement

Kingsley Court 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 07 - Safeguarding people who use services from abuse

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 June 2011, reviewed information from stakeholders and talked to people who use services.

What people told us

The people living at Kingsley Court have varying levels of capacity to give us their views on the service being provided. During our unannounced visit to the service on, 03 June 2011, we observed that there was a busy positive atmosphere. Staff were supporting people to follow their individual activity plans, which for some included going out to a football session. One person was meeting with the manager of another service to consider moving there and another person went out on their own during the morning and came back with boxes to pack up their belongings. The provider has recently told the people living at Kingsley Court that the service was closing and plans were being made to find them alternative accommodation.

What we found about the standards we reviewed and how well Kingsley Court was meeting them

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

The provider is not compliant with this outcome because the organisation's management, reporting and monitoring systems have not protected people from the risk of abuse.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 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. Any regulatory decision that CQC takes 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 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

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The people we spoke with during our unannounced visit, on 03 June 2011, did not raise any concerns regarding their safety, the quality of the service or the staff supporting them. We observed that people were relaxed and comfortable in their surroundings.

Other evidence
We carried out this review of the service because of concerns regarding the safety of people living at Kingsley Court, which were identified through notifications sent to us by the manager and reports from local authority safeguarding investigations. These concerns included reports of two serious incidents of assault within the service on 19 and 20 April 2011 and possible financial irregularities. Hertfordshire County Council led a multi-agency safeguarding of vulnerable adults investigation. The outcome of the safeguarding investigations and independent financial audit, commissioned by the provider as part of the review, identified a failure to keep adequate financial records, lack of robust policies and procedures for managing money belonging to people who use the service and monitoring of management arrangements. Not all incidents that took place within the service were considered and reported under safeguarding procedures. This means people may not be protected from abuse because appropriate management arrangements were not provided and professionals who represent people living at Kingsley Court were not kept informed regarding the nature and severity of some incidents so they could take further action if required. The provider has sent us a copy of the action plan put in place following the financial audit, to ensure there are adequate controls and oversight of financial procedures. We have not yet had the opportunity to see the outcome of this in relation to people who use the service

because the service is currently closed.

While this review was in progress the provider informed us of their intention to temporarily close Kingsley Court so the company could carry out a review of the type of service provided from this location. We were advised the decision was not related to the investigations currently taking place but was taken for operational reasons. Arrangements had been put in place to provide the seven people currently living at Kingsley Court with support from their representatives and commissioning authorities.

We carried out a joint unannounced visit to Kingsley Court, on 03 June 2011, with a social worker from Hertfordshire County Council, as we had received information that the acting manager had been suspended by the provider, with immediate effect, in relation to issues identified at another service. This meant we were concerned about the stability of the management arrangements during this vulnerable period when people were moving out.

During our visit to the service we noted a lack of leadership and confidence among the staff present, which meant standards, had slipped in some areas. These included; a delay in administering someone their medicine because staff had not followed the company procedure for recording the information on the administration chart, staff not feeling empowered to cover unexpected gaps in the rota arising out of staff sickness, odour in an area of the home and reduced stocks of fresh food, such as fruit, in the kitchen.

The area manager for the service arrived during our visit with the person who was to take over as acting manager. We were able to have a full discussion about the concerns we had identified during our visit. A plan was developed to keep us notified of the action taken and support being provided to the people living at Kingsley Court to maintain the safety and quality of the service as they moved to alternative accommodation. Following our visit evidence of the action taken by the provider to address the issues we had raised was sent to us.

Our judgement
The provider is not compliant with this outcome because the organisation's management, reporting and monitoring systems have not protected people from the risk of abuse.

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: The provider is not compliant with this outcome because the organisation's management, reporting and monitoring systems have not protected people from the risk of abuse.	
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: The provider is not compliant with this outcome because the organisation's management, reporting and monitoring systems have not protected people from the risk of abuse.	

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 28 days of this report being received.

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

Document purpose	Review of compliance report
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