Review of compliance

Royal Mencap Society Royal Mencap Society - 12 Wales Street	
Region:	East Midlands
Location address:	12 Wales Street Rothwell Kettering Northamptonshire NN14 6JL
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	12 Wales Street is a small residential home which is owned and managed by the Royal Mencap Society. It is registered to provide accommodation for people who require nursing or personal care for up to four residents.

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

Our current overall judgement

Royal Mencap Society - 12 Wales Street 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 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 29 November 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

There were four residents living at the service when we visited on 29 November 2011. We spoke with two members of staff to ask for their comments and observations. We spent some time in communal areas of the home with two residents, observing their experience of care and assessing the quality of support they received.

What we found about the standards we reviewed and how well Royal Mencap Society - 12 Wales Street was meeting them

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

People received effective, safe and appropriate care and support which met their needs.

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 had systems in place to monitor the quality of care that people 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 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 spoke with two residents who said they were happy living at the home.

Other evidence
We observed that staff provided good support to residents.

We looked at the two residents' care records which clearly showed their likes and dislikes and how they would like to be supported by staff. Residents had been supported to make detailed personal records of what was important to them. One resident had a book of her favourite hymns as part of her record. Another resident had a notice board in her room to record going for medical check ups.

Residents had a full programme of activities to suit their needs. We were told that residents often went out in the local community to the shops and the bank and also attended day centres. One resident liked to visit a nail bar and also went to a Salvation Army group. Another resident was supported to go to bowling and swimming and attended a club. Residents had contact with their families and friends. One resident had attended staff training courses and made her own greetings cards which she sold at the day centre to make money to buy more materials.

We saw minutes of monthly meetings where residents discussed menu choices and activities they would like to do. Menu choices and activities were put in place were possible to meet the residents' wishes.

The staff we spoke with said they enjoyed working at the home and it was a happy atmosphere to work in.

Our judgement
People received effective, safe and appropriate care and support which met their needs.

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
We did not speak with residents about assessing and monitoring the quality of service provision.

Other evidence
There were systems in place to assess and evaluate the quality of service provided by the home.

We were told by the manager that there was a monitoring system on the computer which showed when care records and risk assessments needed to be reviewed and when staff needed updates to training.

We looked at checks carried out on building maintenance and any issues were noted and the date the work was carried out was recorded. We saw that fire safety checks were carried out.

A survey was carried out with relatives of the residents in June 2011 which showed that people were satisfied with the support provided at the home. There were volunteers who visited the residents and one resident in particular to make sure that they were well supported.

Our judgement
The provider had systems in place to monitor the quality of care that people 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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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