Review of compliance

Royal Mencap Society Royal Mencap Society - 75-77 Wickstead Avenue	
Region:	East
Location address:	75-77 Wickstead Avenue Luton Bedfordshire LU4 9DW
Type of service:	Care home service without nursing
Date of Publication:	February 2012
Overview of the service:	75-77 Wickstead Avenue is a care home registered to provide accommodation for persons who require nursing or personal care. The home provides a service for up to five people who have a learning disability, and does not currently provide nursing care. At the time of this review, discussions

	were taking place about the possibility of changing the type of service from a care home to a supported living service.

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

Our current overall judgement

Royal Mencap Society - 75-77 Wickstead Avenue was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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, carried out a visit on 19 January 2012, checked the provider's records, 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

People that we spoke with, told us they were happy living in the home and with the support they received.

They talked to us about some of the ways that they were being encouraged to maintain their independence such as doing their own laundry and laying the table for dinner.

One person talked about taking more control over their own cooking, medication and personal finances under proposals for the service to change to a supported living service in the future.

People we spoke with confirmed that they liked the staff, and that they supported them well.

What we found about the standards we reviewed and how well Royal Mencap Society - 75-77 Wickstead Avenue 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

The provider is compliant with this outcome. People using the service are respected and involved in making decisions about their care and support.

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

The provider is compliant with this outcome. People using the service experience safe and appropriate care and support. However the provider must not become complacent in terms of reviewing the compatibility of people living in the home, and ensuring that everyone's best interests are promoted and upheld.

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

The provider is compliant with this outcome, but to maintain this we have suggested some improvements are made.

People using the service are protected from abuse, or the risk of abuse however, the practice of using key pads on the front doors needs to be reviewed to ensure people living in the home are safe in the event of a fire, and are not subject to unnecessary or inappropriate levels of restraint.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The provider is compliant with this outcome. The provider has systems in place to ensure there are sufficient numbers of staff with the right knowledge, to support people living at the home.

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 is compliant with this outcome. Systems are in place for assessing and monitoring the quality of service provision.

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 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
During our visit on 19 January 2012, people talked to us about some of the ways that they were being encouraged to maintain their independence such as doing their own laundry and laying the table for dinner.

One person talked about taking more control over their own cooking, medication and personal finances under proposals for the service to change to a supported living service in the future.

Other evidence
Some useful information about the home and about the support offered to people using the service, had been developed in an easy to read format - using pictures and symbols.

During our visit, we spent time directly observing the support being provided to people living in the home, to help us determine what it is like for people living at Wickstead Avenue. We took into account the outcomes for people who use the service, people's levels of engagement and staff interactions. We observed some positive engagement between staff and people using the service. Staff demonstrated a confident approach, and were able to show that they had a good understanding of people's needs. Staff

were seen and heard encouraging people to focus on a variety of different activities when they became distressed, and this approach prevented some potentially volatile incidents from occurring. Staff communicated in a calm, friendly and respectful manner at all times, and people living in the home appeared to respond well as a result.

The manager spoke about plans to change the service from a care home to a supported living service in the future. She said that she planned to arrange for an independent advocacy agency to come to talk with people living in the home about the proposed changes. People we spoke with during our visit confirmed that they were aware of the situation, and discussed some of the ways that this might affect them as individuals and as a group.

Systems such as periodic surveys were in place to give people using the service the opportunity to feedback on the service provided, and to contribute to the running of the home.

Our judgement
The provider is compliant with this outcome. People using the service are respected and involved in making decisions about their care and support.

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
People that we spoke with, told us they were happy living in the home and with the support they received.

Other evidence
We looked at a sample of records for two people living in the home and found some clear information about their needs, preferred routines, likes and dislikes. There were clear references to corresponding risk assessments and separate health care records. Pictures had been included in the plans we saw, to make the information more accessible. A separate audit tool had also been developed to ensure plans were being reviewed on a regular basis, and routine health care appointments for people living in the home were not overlooked.

During our visit we heard one person living in the home screaming loudly at regular intervals. Guidance was available to support staff in managing the situation, in the best interests of the person and other people living in the home. We noted that the guidance was followed when incidents occurred during our visit however, we did see one person who was visibly affected by the noise, and saw that they turned their head away to help them to manage this. Records showed that the person who was screaming was getting up on a regular basis at night. On eight occasions in the last three months, the person had also triggered an internal alarm, which had been fitted to enable staff on duty at night, to be aware of their movements. Staff confirmed that there was only one sleeping member of staff at night and because of this, and the location of the alarm system in the house, there was a risk that other people living in the home would be affected by the

disruption. We spoke to the manager about this, who confirmed that she was aware of the situation and that it was being monitored. Records supported this. External healthcare professional advice had also been sought.

Most people living in the home were attending regular external day care activities during the week. Staff spoke about a recent change where staff costs for social outings and activities were no longer funded by the service, and we were told that staff now needed to cover their own costs when taking people out, or opt for no cost options. Staff said that they were not all in a position to pay their own costs, and were concerned that people living in the home might stand out from other social groups when out in public, as a result. People living in the home confirmed that they had begun to notice that staff were no longer eating and drinking the same things with them at home, or when they went out. At a recent inspection of another service run by the same provider, we were told that the organisation was looking at ways to manage the situation, to ensure that people using the service did not miss out on activities and outings under the new arrangement.

Contact with families and friends was supported and welcomed. We saw photographs from a party that had recently been held for one person living in the home, which had included members of their family.

Our judgement
The provider is compliant with this outcome. People using the service experience safe and appropriate care and support. However the provider must not become complacent in terms of reviewing the compatibility of people living in the home, and ensuring that everyone's best interests are promoted and upheld.

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
We did not request information from anyone using the service about this outcome during our visit on 19 January 2012.

Other evidence
Appropriate systems, policies and procedures were in place to ensure people living in the home were being protected from abuse, or the risk of abuse. Records showed that the home worked collaboratively with other services, teams and agencies in relation to safeguarding matters.

The manager told us that all staff working at the home had received up to date training regarding the safeguarding of vulnerable adults. Staff had also received training to support people whose behaviour might at times put them, or those around them at risk. Guidelines had been put in place to support staff to manage particular situations, which had been developed in agreement with the people involved.

Key pads had been fitted to the front doors of the home, and the manager explained that anyone wanting to leave the property would need first to type the correct code into the key pad. The key pads had been fitted to prevent people deemed to be at risk, from leaving the property without staff being aware. The manager confirmed that the key pads were not linked to the home's fire alarm system, and would therefore not automatically unlock in the event of there being a fire; meaning that people living in the home, staff and visitors were potentially at risk. The manager had already identified this risk and told us that she was communicating with the local fire authority and the

housing association responsible for the building, to ensure that people living in the home were both secure and safe in the future.

However the arrangement also raised concerns about whether people living in the home were subject to inappropriate levels of restraint - through the locking of the front doors. We noted that the key pad codes were easily accessible to anyone who was able to read, but this was not the case for all the people living in the home. The service had considered the impact of the arrangement on people and individual risk assessments were in place as a result. However, risk assessments that we saw did not contain sufficient information to say whether the use of the key pads was justifiable. For example one person had been risk assessed as being safe to go out to a local shop on their own, so it was unclear why they also had a risk assessment about the need for a key pad to be in place, preventing them from going out. We brought this to the attention of the manager during our visit who was clear that the key pads were in place to safeguard people living in the home, but that risk assessments needed to be reviewed and updated to reflect people's individual needs and circumstances.

We observed staff treating people with respect throughout our visit, and helping them to make their own choices and decisions.

Our judgement
The provider is compliant with this outcome, but to maintain this we have suggested some improvements are made.

People using the service are protected from abuse, or the risk of abuse however, the practice of using key pads on the front doors needs to be reviewed to ensure people living in the home are safe in the event of a fire, and are not subject to unnecessary or inappropriate levels of restraint.

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
People we spoke with confirmed that they liked the staff and that they supported them well.

Other evidence
During our visit, we observed there to be sufficient staff on duty to meet the needs of the people living at the home. Staff were able to demonstrate that they understood the needs of the people they were providing support to, and we observed how they supported two people to manage their anxieties through positive communication, distraction techniques and involvement in daily living tasks.

The manager confirmed that the service was fully staffed and that a new member of staff had just completed their induction training. Staff were observed working well together, and the manager was complimentary about the team as a whole.

Training records showed that the staff had recently been trained in a number of important areas required to meet the needs of the people living at Wickstead Avenue. This included the safeguarding of vulnerable adults, lone working, people handling, medication and food hygiene. The manager had a system in place for identifying gaps in staff training or when refresher training was due.

Training regarding supported living and the proposed changes to the service, had begun or was planned for staff. The manager informed us that training to support staff in meeting the changing needs of the people living in the home was also in the process

of being arranged. Records supported this.

Our judgement
The provider is compliant with this outcome. The provider has systems in place to ensure there are sufficient numbers of staff with the right knowledge, to support people living at the home.

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 request information from anyone using the service about this outcome during our visit on 19 January 2012.

Other evidence
Systems such as audits and periodic surveys were in place to monitor the quality of service provision, and to give people using the service the opportunity to contribute to the running of the home.

The provider had developed an evidence-based, year on year improvement system which had been tailored to meet the needs of the people using the service. A continuous improvement plan for Wickstead Avenue had been developed as a result, which incorporated regular checks undertaken in relation to individual support needs, system improvements, the environment and safety. The plan showed that action had been taken to address areas identified as requiring improvements in the months prior to our visit. We noted too that overall, care plans had been updated to reflect when people's individual goals had been achieved.

The views of people using the service were being sought on an ongoing basis, and through satisfaction surveys. The results from surveys completed by people using the service in 2011, showed that they were satisfied with the support they were receiving.

Surveys had not been sent out to families and other stakeholders at the time of our visit. However, we did read some recent review meeting minutes for one person, which

recorded that their family was happy with the support being provided.

Our judgement
The provider is compliant with this outcome. Systems are in place for assessing and monitoring the quality of service provision.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

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
	Why we have concerns: People using the service are protected from abuse, or the risk of abuse however, the practice of using key pads on the front doors needs to be reviewed to ensure people living in the home are safe in the event of a fire, and are not subject to unnecessary or inappropriate levels of restraint.	

The provider must send CQC a report about how they are going to maintain 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.

CQC should be informed in writing when these improvement 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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