Review of compliance

Autism TASCC Services Limited Collinson Court	
Region:	West Midlands
Location address:	56 Longton Road Trentham Stoke on Trent Staffordshire ST4 8NA
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	Collinson Court provides accommodation and personal care for ten people who have a learning disability.

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

Our current overall judgement

Collinson Court 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 to check whether Collinson Court had made improvements 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 4 January 2012, carried out a visit on 12 December 2011, looked at records of people who use services and talked to staff.

What people told us

We undertook this review as we had not visited for some time and we wanted to see what life was like for the people who lived in the home.

Everyone had a plan of care that identified their needs. This included information about any communication needs and any support people needed to manage their behaviour. People's daily preferred routines were identified.

People who lived at the home were supported to have their health and personal care needs met. People saw the GP when they were ill and had regular checks with health care specialists to monitor their health.

Staff knew about how people made their needs and wishes known. Individual plans were in place to support people communicate their needs. For example some people used pictures and symbols and one person used some makaton signs. Communication dictionaries helped staff to understand people's non verbal communication.

Staff were trained to understand and manage any difficult behaviour through the use of redirection and de escalation methods.

People were supported to make choices and to be as independent as possible. Some people helped around the home doing household tasks. People chose what they wanted to

eat and the activities they wanted to do.

The home had systems in place to monitor and evaluate people's care. Plans of care were reviewed monthly through key worker meetings. A risk management system assessed and put in place plans to make sure people were kept safe.

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

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

People who live at the service receive safe, effective care that meets their individual 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

People who live at the service benefit from safe care due to the effective monitoring and management of risks to their health and welfare.

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 were not able to gain the views of the people that lived at the home due to their specialist needs. We spoke to several relatives who were regular visitors to the home. They were all very positive about the care their relative received. They said that people were treated as individuals and that their health and personal care needs were met. Comments included "brilliant" and "the home meets their needs", and 'I Can't praise them high enough". One relative said that their relative liked football and music and the staff encouraged them in these interests. They also said they were supported by a staff member to take their relative out every week and that staff always kept them informed of any changes. She said that the staff made sure their relative's health needs were met and they were aware if there was any deterioration in their health.

Through a process called 'pathway tracking', we followed the care of two people who lived in the home. We looked at the care records of these people and spoke with staff about the care they received. We also observed staff when they provided support. Pathway tracking helps us understand the outcomes and experiences of selected people as we look at documentation relating to them and observe the care given. The information we gather helps us to make a judgement about whether the service was meeting the essential standards of quality and safety.

Each person had a comprehensive plan of care that was centred around their specific needs and preferences. Plans gave information about people's health and personal care needs, as well as their preferred daily routine and activities. Specialist communication and behavioural needs were identified and included strategies to help

staff respond in an appropriate way. The home was in the process of updating their plans to make them more accessible both to people living at the service and to make them more effective as working documents.

Pathway tracking confirmed that people were having their health care needs met. We saw evidence of people seeing the GP when they were ill and seeing specialist health care staff for regular medical reviews. People also received well women and well men checks. Records confirmed that people had eye and dental checks.

We observed that people's personal care needs were being met. This was confirmed by relatives we spoke to. People had daily baths or showers, had their nails and hair done and were dressed appropriately. People were supported to make choices including what their wore, what food they ate, when they go up and went to bed and over the activities they did. Each person had a daily routine identifying how they liked their care to be provided.

Staff supported people to have their medication. There was evidence of medication reviews taking place. Medication was stored in a locked cupboard in each person's bedroom. An examination of medication administration records showed them to be completed correctly including explanations when medication was not given or altered. Some people had medication 'as required' and protocols were in place. The manager agreed to further develop these so that it was more clear when this medication should be given. Staff we spoke to said they had been trained in medication administration and that they had annual competency assessments.

Some people displayed behaviour that challenged. Comprehensive plans were in place showing staff how to respond in different situations. Triggers for behaviour were identified and incident charts completed in order for managers to analyse specific incidents to see if situations could be managed in a better way. Staff we spoke to confirmed they had received training in de escalation and redirection methods. They were aware of triggers and how to respond to people's behaviour and could provide examples of how some behaviours had reduced. The manager told us that the company had its own psychologist and was seeking up to date psychological assessments to provide further advice on managing people's behaviour.

People with specialist communication needs had a communication plan. This included a communication dictionary giving staff examples of what how people communicated non verbally. For example for one person if they injured themselves it could indicate that they were in pain and for another person rubbing their stomach could indicate they felt ill. We also saw that there were specific techniques used for communication. One person used some makaton signs and other people communicated their wishes through pictures and and symbols.

We observed that some people were supported to help around the home. For example one person enjoyed mopping the floor, another person made their own drinks, some people helped with the laundry and others were involved in tasks such as laying the table.

People took part in a range of activities. Records showed the activities people liked and we saw records to evidence that people had been supported to take part in these activities. For example one person enjoyed going on their bike and this occurred

regularly and another person liked going out for walks and this occurred. Three people attended courses at college. The manager did feel that people could take part in more community activities and was investigating how this could be achieved. We saw that the staff supported people to do a range of activities in the home. For example we saw pictures people had painted and we saw one person making patterns with beads. The home had a small gym/ exercise room and people were encouraged to use this facility.

Other evidence
We spoke with three staff that worked at the service. They were able to tell us about people's needs and their preferred routines. Their knowledge about people corresponded with the information in the plans of care. Staff were aware of how people communicated and confirmed the use of pictures and symbols to help people express their wishes. All the staff said they had received training in managing difficult behaviour and were aware of redirection and de-escalation techniques. They confirmed that the home did not use any physical restraint to manage people's behaviour.

Staff were aware of the importance of promoting people's dignity. They explained how they maintained people's right to privacy through for example knocking on bedroom doors and giving people as much privacy as possible when supporting them with personal care tasks. They also told us how they encouraged people to be as independent as possible describing how people helped with household tasks and made decisions about their daily life.

Our judgement
People who live at the service receive safe, effective care that meets their individual 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 spoke with a relative who said that the home kept in touch with them and kept them informed of any changes. They also said that they felt able to raise any concerns with the staff and were confident that it would be dealt with.

The home had a system in place to review all plans on a monthly basis and this included gaining the views of the people that live there. These reviews covered all aspects of a person's care including the activities they had done and whether these had been enjoyed. These were monitored and evaluated by the managers.

Other evidence
The home provided us with evidence of their auditing systems that were in place to monitor and evaluate the care provided to the people that lived there. We saw evidence that audits were completed on the environment, infection control and food safety practices, medication and incidents and accidents. Additionally the provider completed a monthly monitoring visit by an external manager.

Plans of care were reviewed regularly. There was a comprehensive risk management system in place. Risks to each person were assessed and plans in place to make sure care was provided safely.

Our judgement
People who live at the service benefit from safe care due to the effective monitoring and management of risks to their health and welfare.

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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Author	Care Quality Commission
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