Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Fouracres Care Services

47 Fouracres, Enfield, EN3 5DR

Tel: 02082924823

Date of Inspection: 27 January 2014

Date of Publication: February 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Supporting workers	✖ Action needed

Details about this location

Registered Provider	Mrs Philomena Chikwendu Okoron-Kwo
Registered Managers	Mr. Simon Atkins Ms. Omonigho Ekata
Overview of the service	Fouracres Care Service is a care service that provides accommodation and care to a maximum of four people who have learning disabilities.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 27 January 2014, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by other authorities and talked with other authorities.

What people told us and what we found

We received information of concern that people's care needs were not being met as staff were not always available and were not trained to meet their needs. On arriving at the service we found one member of care staff and the manager working at the home. Two people were using the service. One person came out of their bedroom and appeared to be distressed. Although staff were aware of this they did not come and support the person.

We looked at one person's care plan and found that it did not show how the service would support them to develop their independent living skills. Apart from attending a work placement each week there was no other evidence his care plan that showed how the person's skills would be further developed. Staff spoken to could not tell us how they would work with the person to enable them to be more independent. We asked both staff and the manager how an emergency situation would be handled when only one member of staff was working in the service. They could not tell us how they would respond to a medical emergency.

We looked at the training records for the four staff currently working at the service. These showed that there were number of areas where all staff had not completed the relevant training. We saw that one person needed specific support in developing their independent living skills. Records showed that no staff had received this training.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 27 February 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare as staff were not available to meet people needs and arrangements were not in place to deal with foreseeable emergencies. Regulation 9 (1)(b)(i)(ii)(2).

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We received information of concern that people's care needs were not being met as staff were not always available to meet their needs. On arriving at the service we found one member of care staff and the manager working at the home. Two people were using the service. One person came out of their bedroom and appeared to be distressed. Although staff were aware of this they did not come and support the person.

The manager told us that the number of staff on duty had recently been decreased from two to one member of staff on each shift. This decision had been taken by the provider as they were only two people currently using the service. We looked at the rota and this showed that one member of care staff were on duty each day. This meant that they worked 12 hours and then slept in and finished their work the following morning. We asked the manager if any assessment had been carried out to determine whether one member of staff could meet the needs of the two people using the service. He told us that no assessment had been carried out to ensure that one member of staff could meet people's needs safely.

We looked at two people's care records. One person care records showed that there needs had recently been reviewed by their social work. The manager explained that the person was being considered for a move to supported living so that they could live more independently. We looked at the person's care plan and found that it did not show how the service would support them to develop their independent living skills. Apart from attending a work placement each week there was no other evidence in their care plan that showed how the person's skills would be further developed. Staff spoken to could not tell us how they would work with the person to enable them to be more independent. The manager

confirmed that since he started working at the service in September 2013 he had not seen staff work with the person to develop their skills. The manager told us that as there were only one member of staff on duty it would not be possible for them to spend time helping the person to develop these skills. This meant that care may not be delivered to enable people to be as independent as they could be.

Another person's care plan showed that they needed one to one support from staff when accessing community based activities. They had an activities plan for the week and we saw from daily notes they had been able to access the community. However, daily notes also showed that this had not been as regular as staffing had been reduced from 2 to 1 each shift. Daily notes also showed that a number of activities (for example, drum circle) had not been carried out. The manager was not able to explain why these activities had not been carried out. This meant that the person may not be supported to meet all the needs regarding accessing the community.

People may be at risk as appropriate procedures were not in place to address emergencies which were reasonably expected to arise in the service. We asked staff and the manager how an emergency situation would be handled when only one member of staff was working in the service. They could not tell us how they would respond to a medical emergency. Staff said that they would call the manager if they needed support in the event of a medical emergency. However, the manager told us it would take them at least 20 minutes to get to the service if this happened. Staff also told us that they would have to stay at the service to support the other person who used the service and if necessary an ambulance would have to take the person without anyone to accompany them. People's care records showed that they had communication needs that meant they would not be able to explain to health professionals what their medical needs were. Training records showed that only one member of staff currently has a first aid qualification.

We looked at people's risk assessments these did not show how staff were to respond to a medical emergency. We asked the manager whether procedures had been reviewed regarding how medical emergencies should be handled to reflect that one member of staff was now on duty throughout the day. The manager told us that the procedure had not been reviewed.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

Staff did not have all the skills needed to provide safe and appropriate care to people as they were not receiving appropriate training. Regulation 23(1)(a).

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We received information of concern that told us that staff had not received all the training they needed to meet the needs of people use the service. We looked at the training records for the four staff currently working at the service. These showed that staff had only completed training in health and safety and Adult protection training in 2013. We asked the manager what he had done to address this. The manager said that he had started to identify training for staff, but no training had been planned or delivered since he started at the service in September 2013.

Training record showed that there were number of areas where all staff had not completed the relevant training. For example, only one of the four members of staff had completed medication training, two of the four staff had completed challenging behaviour training in 2012 and only one member of staff had a first aid certificate (completed in 2012). There was no evidence that showed staff had received training in breakaway and restraint techniques.

We saw that one person needed specific support in developing their independent living skills. Records showed that no staff had received this training. The manager told us that he felt that staff needed to develop their skills in this area. We asked what had been done to address this. The manager explained that no training had currently being provided and that he had just started to identify possible providers of this training.

We asked the manager whether he had a training matrix to show how and when staff would require training. He told us there was no training matrix to show how staff would receive training updates. This meant that staff did not have all the skills to meet the needs of people safely.

Staff said that they had been supervised and supported in their work with people. There were records of supervision available. Staff told us that they had received an appraisal in the last year.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare as staff were not available to meet people needs and arrangements were not in place to deal with foreseeable emergencies. Regulation 9 (1)(b)(i)(ii)(2).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Staff did not have all the skills needed to provide safe and appropriate care to people as they were not receiving appropriate training. Regulation 23(1)(a).

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 by 27 February 2014.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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