Community Options

Community Options Limited - 56 High Street

Inspection report

56 High Street
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Ratings

Overall rating for this service	Good
Is the service well-led?	Good

Overall summary

This focused inspection took place on 21 October 2015 and was unannounced. At the previous comprehensive inspection on 31 March 2015 we had found a breach of the legal requirements in that the provider had failed to notify the Care Quality Commission (CQC) without delay of incidents that occurred within the home.

We carried out this inspection on 21 October 2015 to check action had been taken to address the breach of legal requirements. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Community Options Limited - 56 High Street on our website at www.cqc.org.uk.

Community Options 56 High Street, Chislehurst, Kent, provides accommodation and support for up to ten people with learning disabilities and mental health issues. At the time of our inspection the home was providing care and support to ten people.

There was a registered manager in post at this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection on 21 October 2015 we found that the service had robust systems in place to ensure that reportable incidents were recorded correctly and notifications were sent to the appropriate organisations such as the CQC and local authority where required.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Good

The service was well-led.

The service had robust systems in place to ensure that reportable incidents were recorded correctly and notifications were sent to the appropriate organisations such as the CQC and the local authority where required.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This was a focused inspection and was carried out to check that improvements had been made to address the breach of legal requirements found at our comprehensive inspection on 31 March 2015. We inspected the service against one of the five questions we ask about services: 'Is the service well led?' This is because the service was not meeting legal requirements in relation to that question at our last inspection.

This inspection was unannounced and was carried out by a single inspector on 21 October 2015. Before the inspection we looked at the information we held about the service, including information from any notifications they had sent us. A notification is information about important events which the provider is required by law to send us.

We looked at the care plans and records of two people using the service and records relating to the management of the service such as reportable notifications including accidents and incidents involving people using the service. We also spoke with a senior member of staff.

Good

Is the service well-led?

Our findings

At our last inspection on 31 March we found that the provider had failed to notify the Care Quality Commission without delay of incidents that occurred within the home as required to do so by law. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

At this inspection we found the service had robust systems in place to ensure that reportable incidents were recorded correctly and notifications were sent to the appropriate organisations such as the CQC and the local authority where required.

We looked at the home's accident and incident folder which showed that there had been 18 documented accidents and incidents at the home since April 2015. We saw that these recorded incidents corresponded with the notifications received by the CQC where appropriate. For example one incident record detailed how one person had suffered from a fall causing minor injuries which required medical treatment. We saw that the person was taken to hospital to receive medical treatment and later returned to the home. We looked at the person's care plan and saw that the incident was documented appropriately and noted there was an up to date risk assessment in place to minimise the risk of further falls. We saw that the home had notified the CQC regarding the incident as appropriate.

We found that the provider had addressed the breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.