PBT Social Care Ltd

Simone's House

Inspection report

41 & 41a Hillingdon Road
Uxbridge
Middlesex
UB10 0AD

Tel: 01895745712

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28 March 2017

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Ratings

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 20 and 24 October 2016. A breach of a legal requirement was found because two safeguarding concerns and one police incident were not reported to the Care Quality Commission as required under the Regulations. After the comprehensive inspection, the provider submitted an action plan, dated 29 November 2016, detailing what they would do to meet the legal requirements in relation to the breach.

We undertook this focused inspection on 28 March 2017 to check that the provider had followed their plan and to confirm that they now met the legal requirement. This report only covers our findings in relation to the requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Simone's House on our website at www.cqc.org.uk.

Simone's House provides accommodation for up to four adults who might have a range of needs, including acquired brain injuries, learning disabilities and/or autism and people recovering from a stroke. There were three people using the service at the time of the inspection.

The service had a registered manager who had been in post since February 2014. 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 our focused inspection on 28 March 2017, we found that the provider had not followed all of their plan of action, and that the legal requirement had not been fully met.

The provider failed to notify CQC of one serious incident, however, they had sent through three notifications appropriately and as required.

The service did not have a central register of accidents and incidents to monitor and analyse all accidents and incidents that took place at the service.

The registered manager and staff working at the service were aware of the service's responsibility to submit statutory notifications.

We could not improve the rating for well-led from requires improvement because the provider had not fully complied with the regulation. To improve the rating requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

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?

Requires Improvement

The service was not always well led.

The service did not notify the CQC about one serious incident that involved a person using the service.

The service did not have a central register of accidents and incidents to monitor and analyse all accidents and incidents that took place at the service.

The service had sent three notifications appropriately and as required.

Staff members were aware of the service's responsibility to submit statutory notifications.

We could not improve the rating for well-led from requires improvement because the provider had not fully complied with the regulation. To improve the rating requires consistent good practice over time. We will check this during our next planned comprehensive inspection.

Simone's House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced focused inspection of Simone's House, a residential care home, on 28 March 2017. This inspection was carried out to check that improvements to meet the legal requirement planned by the provider after our comprehensive inspection on 20 and 24 October 2016 had been made. The service was inspected against one of the five questions we ask about services: Is the service well led. This was because the service was not meeting some legal requirements at our last inspection.

Prior to the inspection, we looked at all the information we held on the service including the last inspection report, the provider's action plan which set out the action they stated they would take to meet the legal requirement, notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about.

The inspection was undertaken by a single inspector. During the inspection, we spoke with the registered manager, the deputy manager and a staff member. We looked at the incident and accident, safeguarding and complaints records.

Requires Improvement

Is the service well-led?

Our findings

At the inspection on 20 and 24 October 2016, we found that the provider had not notified the Care Quality Commission (CQC) about two potential safeguarding concerns and an incident that had involved a person using the service calling the police. This meant the provider did not follow their legal duty to submit statutory notifications as required by the Regulations.

During our inspection on 28 March 2017, we saw that some improvements had been made, but further improvements were still needed.

Prior to the inspection on the 28 March 2017, we reviewed the information we held about the service. We saw that since the inspection in October 2016 the service had sent notifications to inform CQC of one unexpected death, one Deprivation of Liberty Safeguards (DoLS) application outcome and one incident reported to the police. The registered manager informed us that since the last inspection there were no other incidents or new safeguarding concerns that needed to be reported to CQC. However, when we looked at incident records for one person using the service we saw that an incident took place where this person had felt unwell and was taken to hospital where they were admitted for eight days. The service had not informed CQC about this incident. We spoke about this with the registered manager who said they would notify CQC of such incidences in the future.

During our visit, we discussed with the registered manager their responsibility to notify the Commission if a variety of incidents took place while people were receiving support from the service. The registered manager understood their responsibility and was able to list a range of incidents where a statutory notification would be necessary. We saw that since the inspection in October 2016 the service had submitted all but one notification as required.

At the latest inspection, there was evidence the service had not followed all actions detailed in the action plan dated 29 November 2016. In the plan, the registered manager stated they would audit all incidents and accidents at the service in order to ensure all respective persons and organizations were notified as required. However, during our visit the registered manager told us they did not have a central accidents and incidents register and they did not monitor and analyse all accidents and incidents that took place at the service. The registered manager agreed that a register of this type was required and stated they would implement one.

The service did not have a central safeguarding register. The registered manager explained any future safeguarding concerns would be recorded and placed in a general safeguarding folder.

The registered manager told us they discussed the subject of statutory notification with their staff team. Staff we spoke with confirmed the discussion took place. Additionally, the registered manager requested all staff members to read the CQC notifications procedure that was available for staff to view in the office. We saw two notes from the registered manager in a staff communication book confirming that such a request had been made.