Review of compliance

Dimensions (OWL) Limited Dimensions - 237 Courthouse Road	
Region:	South East
Location address:	237 Courthouse Road Maidenhead Berkshire SL6 6HF
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	237 Courthouse Road is a care home without nursing situated near St Mark's hospital in Maidenhead. The service provides four beds across two floors of a large detached house. Three of the bedrooms have a wash basin and access to a shared bathroom. One room has an en-suite bathroom. The service has a good size garden with several fruit trees and provides residential care to people experiencing a learning disability

	and/or autistic spectrum disorder.

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

Our current overall judgement

Dimensions - 237 Courthouse Road 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 10 October 2011, observed how people were being cared for and talked to staff.

What people told us

The people that use the service at 237 Courthouse Road experience varying degrees of learning disability and therefore we were unable to talk with them about their experiences. To help us to understand the experiences people have we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences. We found that overall people had positive experiences. The staff supporting them knew what support they needed and they respected their wishes if they wanted to manage on their own. The support that we saw being given to people matched what their care plan said they needed. Staff responded to people in a calm and respectful manner.

What we found about the standards we reviewed and how well Dimensions - 237 Courthouse Road 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

People who use the service had their privacy, dignity and independence respected and were receiving information in relation to their care. People were participating in decisions relating to their care. However, people or those acting on their behalf (such as a relative or advocate) were not having their consent or agreement to the decisions reached recorded.

Overall, we found that 237 Courthouse Road was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People who use the service were experiencing safe and appropriate care. Their needs were being assessed and updated to reflect changing circumstances. People were involved in the planning of their care which was provided in a way they preferred by well informed staff.

Overall, we found that 237 Courthouse Road was meeting this essential standard.

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

People who use the service were protected against the risk of abuse and appeared safe and secure. The service had procedures in place to protect people from abuse. Staff were trained and informed about how to monitor for signs of abuse. However, staff training and information on the Mental Capacity Act (2005) was lacking.

Overall, we found that 237 Courthouse Road was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People had their health and welfare needs met by sufficient numbers of competent and qualified staff.

Overall, we found that 237 Courthouse Road was meeting this essential standard.

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 service had arrangements in place to involve and include people in the running of the service. Quality monitoring systems were used to ensure that people experienced safe quality care.

Overall, we found that 237 Courthouse Road was meeting this essential standard.

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

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
On this occasion we were unable to talk with people who use the service about their experiences.

Other evidence
During our visit the manager accompanied us to people's rooms and would always ask permission from people for us to enter their rooms. One person attempted to undress while we were in her room and we were asked to leave immediately and the door was closed to protect the individual's dignity. One person wanted to make a cup of tea and she was encouraged by staff to do as much as possible for herself while they remained close by to assist if necessary. Staff were seen to regularly engage with people offering them choices and asking about their preferences throughout our visit.

The staff we spoke with gave examples that maintaining a person's privacy, dignity and independence meant closing doors during personal care, always knocking on a door before entering and assisting someone to do as much for themselves as possible. They said that they had received training on privacy and dignity during their inductions. They told us they used their one-to-one time with the people they support to gain feedback from each individual about their care, treatment and choices and also assessed mood and body language to assist them. Staff displayed an awareness of the importance of

asking for a person's opinion and treating each person as an individual rather than making assumptions about their needs and preferences.
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During our visit we carried out a review of care plans. The care plans we looked at contained considerable detail on each person's needs and preferences such as how they like to spend their time and the personal care support they require. One person was recorded as preferring to be independent with making drinks. We saw her making drinks during our observations and staff were close by to assist her when necessary. Another individual's care plan recorded his need to be closely involved with his family. During our visit staff were encouraging him to invite his family members to his birthday party and he appeared to enjoy doing this. We looked at copies of letters concerning charge increases which had been provided in large type with short sentences and picture aids. However, although the various assessments and plans had been signed and dated by staff members, we did not see examples of people or their relatives signing their contribution or agreement to the contents.

Our judgement
People who use the service had their privacy, dignity and independence respected and were receiving information in relation to their care. People were participating in decisions relating to their care. However, people or those acting on their behalf (such as a relative or advocate) were not having their consent or agreement to the decisions reached recorded.

Overall, we found that 237 Courthouse Road was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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
On this occasion we were unable to talk with people who use the service about their experiences.

Other evidence
During our visit we saw that people's rooms were personalised with photographs, ornaments and music collections. In the communal area people were busy with activities such as planning a birthday party and knitting. The activity schedules for each person showed regular attendance at the local day centre for such things as dancing and art sessions. Staff were seen to show an awareness of people's needs and behaviour. During one episode when a person became agitated a member of staff told us: "It's because things are a little different today and it's unsettling for her". On a separate occasion a person was heard mentioning a list of names. A staff member knew that they were his brothers' names and started talking with him about his family. People looked clean, tidy and dressed appropriately. One person remained in her pyjamas most of the morning because she had chosen to do so.

The staff we spoke with told us that they used regular one-to-one meetings with the people they support to identify care needs and review how well they are being met. There were also six monthly reviews of needs assessments and annual updates to risk assessments. They said they were clear that each person's care plan should be updated daily and this should include information about what each individual had been doing during the day, what they had eaten, and their health and mood. They used daily diaries for each person stored with the care plans to this effect. One staff member told

us how the person she supported had visited the service with his family before moving in and she had visited him in his previous service to complete a pre-assessment. Staff were aware that if a person's health changed gradually they would involve the general practitioner (GP) or appropriate medical practitioner. If the health change was more sudden or urgent they would call the emergency services.

During our visit we carried out a review of care plans. The plans we looked at contained clear and well documented risk assessments for such things as mobility, personal safety, and behaviour support. The care plans contained detailed reviews of each person's assessment of needs and information on all the holidays and activities they enjoyed and attended. One person had been risk assessed as likely to choose an unbalanced diet. A dietary assessment, health action plan and monthly weight checks were recorded in her care plan to support a healthier diet. Any changes in health and visits to a GP were well recorded as were follow up actions required by staff.

Our judgement
People who use the service were experiencing safe and appropriate care. Their needs were being assessed and updated to reflect changing circumstances. People were involved in the planning of their care which was provided in a way they preferred by well informed staff.

Overall, we found that 237 Courthouse Road was meeting this essential standard.

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

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
On this occasion we were unable to talk with people who use the service about their experiences.

Other evidence
During our visit we entered the premises several times through an unlocked door. On each occasion we were soon met by a member of staff. We observed staff being relaxed and friendly with people. When people required assistance staff would accompany and guide them. During our observations one person became agitated and began shouting whilst watching the television. Two members of staff approached her to calm the situation. One member of staff stayed with her talking and quietly reassuring her. The person responded well to the member of staff.

The staff we spoke with knew the definition of abuse and that it could be physical, emotional or verbal. They knew to look for such things as a change in a person's mood and behaviour, signs of withdrawal or physical marks such as bruises to identify potential abuse. They said they would speak to their manager or use the whistle blowing procedure if they suspected abuse was taking place and they felt confident and comfortable in doing so. They knew of the service's safeguarding and whistle blowing policies and had reviewed them recently. Some of the staff we spoke with displayed a basic awareness of the Mental Capacity Act (2005). Most of the staff had not received any training on the Mental Capacity Act (2005) in their time at 237 Courthouse Road. We were told that training on the Mental Capacity Act (2005) was not part of the mandatory training requirement for the service.

During our visit we carried out a review of documentation. We looked at the safeguarding and whistle blowing policies which between them defined forms of abuse, how it should be reported and how any allegations would be investigated. The policies had been signed as seen and understood by staff during 2011. We looked at training records which showed staff members had received, or were booked to receive safeguarding training.

We spoke with the manager who displayed a clear understanding of the process involved if a safeguarding incident occurred. This included commencing an investigation and notifying the appropriate authorities such as the local authority safeguarding team (SOVA) and the Care Quality Commission (CQC).

We checked the financial accounts of people who use the service. In each case there were completed transaction records to show how each person's money had been spent. The records were accompanied by receipts. The cash sums for each individual kept in a locked safe matched the recorded balance.

Our judgement
People who use the service were protected against the risk of abuse and appeared safe and secure. The service had procedures in place to protect people from abuse. Staff were trained and informed about how to monitor for signs of abuse. However, staff training and information on the Mental Capacity Act (2005) was lacking.

Overall, we found that 237 Courthouse Road was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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
On this occasion we were unable to talk with people who use the service about their experiences.

Other evidence
During our visit we were aware of a constant staff presence. Staff were seen providing general care to people throughout the service, engaging people, and providing one-to-one support. The staff appeared unhurried and calm in carrying out their duties and did not appear to be overstretched. We saw that where people required one-to-one assistance from a care worker the staff could provide the support without neglecting other duties. Staff were seen to behave in a friendly and approachable manner with people and encouraged people to do as much for themselves as possible. However, the care workers were always available to help when an individual required assistance.

The staff we spoke with had qualifications including a National Vocational Qualification (NVQ) in health and social care. One staff member was due to start an NVQ in learning disability paid for by the service. When they first arrived at the service they said they had received an induction including training in health and safety and moving and handling among others. They said they had been receiving mandatory training in such things as first aid and fire safety and attended additional courses on dementia and epilepsy awareness. They told us they enjoyed being part of the team at 237 Courthouse Road and that people communicated and cooperated well with each other. One member of staff said: "It's quite a nice little team". They said they felt they had enough time to carry out their duties without stress even though there could be busy

periods. They told us they were clear about their line of management and felt they had a good relationship with their manager.

We spoke with the manager who told us that other than herself, two staff covered the day shift. One staff member was on waking duty during the night. The shifts overlapped to allow for adequate handover. She said that the service operated with a total of seven full time permanent care workers but that as one was on long term sick leave an agency worker would be used twice a week to maintain staffing levels.

Our judgement
People had their health and welfare needs met by sufficient numbers of competent and qualified staff.

Overall, we found that 237 Courthouse Road was meeting this essential standard.

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
On this occasion we were unable to talk with people who use the service about their experiences.

Other evidence
The staff we spoke with told us they were aware of a representative of the provider organisation coming to 237 Courthouse Road to complete monitoring audits covering the premises, staff and people who use the service. They said they felt comfortable with the prospect of raising any concerns about the service with their line manager but had never felt the need to do so. They told us that due to the small size of the service it was easy to get input and feedback from relatives of people who use the service and that relatives would often come to the assessment reviews.

During our visit we carried out a review of documentation. We looked at three reports following visits to 237 Courthouse Road by the provider organisation in January, April and May 2011 to monitor the experiences people who use the service, record keeping, staffing and the cleanliness and safety of the premises. The reviews were carried out by representatives of the provider organisation's management team. The service was found to be performing well but where concerns were raised they were accompanied by necessary actions and completion dates.

We were shown an email sent by the operations director on 5 October 2011. The email detailed that as part of a continuing effort to seek the views of people who use the service and their relatives an annual customer satisfaction survey and guidance for staff

was now available. The manager told us she would start using the survey immediately.

Our judgement
The service had arrangements in place to involve and include people in the running of the service. Quality monitoring systems were used to ensure that people experienced safe quality care.

Overall, we found that 237 Courthouse Road was meeting this essential standard.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People who use the service had their privacy, dignity and independence respected and were receiving information in relation to their care. People were participating in decisions relating to their care. However, people or those acting on their behalf (such as a relative or advocate) were not having their consent or agreement to the decisions reached recorded. Overall, we found that 237 Courthouse Road was meeting this essential standard but, to maintain this, we suggested that some improvements were made.	
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 who use the service were protected against the risk of abuse and appeared safe and secure. The service had procedures in place to protect people from abuse. Staff were trained and informed about how to monitor for signs of abuse. However, staff training and information on the Mental Capacity Act (2005) was lacking. Overall, we found that 237 Courthouse Road was meeting this essential standard but, to maintain this, we suggested that some improvements were made.	

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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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA