Inspection Report

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

Dimensions 138 All Saints Road

138 All Saints Road, London, SW19 1BZ

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Date of Inspections: 23 January 2014
19 January 2014
17 January 2014
04 December 2013

Date of Publication: March 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✗ Action needed
Requirements relating to workers	✓ Met this standard
Complaints	✗ Action needed
Notification of other incidents	✗ Action needed

Details about this location

Registered Provider	Dimensions (UK) Limited
Registered Managers	Ms. Grace Brown Mr. David Brum
Overview of the service	The service provides respite care for up to six people with 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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 December 2013, 17 January 2014, 19 January 2014 and 23 January 2014, observed how people were being cared for and talked with carers and / or family members. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by other authorities and talked with commissioners of services. We talked with other authorities and were accompanied by a specialist advisor.

What people told us and what we found

During our inspection visits we met with the registered manager, locality assistant manager, five members of staff and one person that used the service. We also spoke with two people who were relatives of the people who used the service by telephone.

We found care records to be in place for all the people who used the service and we saw that the provider was in the process of updating people's care records. We saw daily notes in the records that showed the care provided and any concerns that were noted at the time.

We saw that all staff received training in safeguarding adults. We also saw from staff records that appropriate checks had been made by the provider to verify staff's suitability to work. This meant there were effective recruitment and selection processes in place.

Appropriate arrangements were not in place in relation to the recording of medicines which meant people were put at risk.

There was an ineffective complaints system. Comments and complaints people made were not responded to appropriately. The complaints records were not analysed to prevent reoccurring themes.

There were several serious incidents that had occurred at the home that had not been reported to the Care Quality Commission.

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 07 April 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 ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Reasons for our judgement

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We looked at care records for five people. In all the records we looked at the needs assessments for people were fairly old dating back to 2011 in one file and 2010 in another file. The assistant manager told us they were in the process on updating care records by inviting relatives and advocates to discuss the most recent care needs. When we spoke to the relatives they confirmed they had been contacted to meet with the staff to update the care needs for their relative. The staff told us they were familiar with any changes to the care needs for the people that stayed at the home because the relatives informed them as and when needed.

The records we looked at contained background information about the person who used the service, what their likes and dislikes were, how and when the person needed to be supported and how they should be supported if there was an emergency evacuation. We saw daily notes in the records that showed the care provided and any concerns that were noted at the time. Risk assessments were in place for example in one persons' record there were risk assessments for choking, hot water, self-harm and communication during an emergency.

The provider may want to note we saw an entry in one of the daily notes indicating that a 'beef stew' had been served when the person who used the service was listed as a vegetarian. This was pointed out to the registered manager during the inspection. When we spoke to the person that used the service they confirmed they had always received vegetarian meals while staying at the home.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We saw that the home had a policy on safeguarding adults. We saw that all staff received training in safeguarding adults. We also saw from staff records that appropriate checks had been made by the provider to verify staff's suitability to work.

We spoke with three members of staff about safeguarding and they were able to tell us about their role in safeguarding people from the risks of abuse and harm. This included how to raise concerns both within the organisation and externally.

Although overall the provider responded appropriately to any allegation of abuse we found that several allegations of abuse that had been reported for investigation had not been reported to the Care Quality Commission (CQC). It is a requirement under the Health and Social Care Act 2008 to report safe guarding incidents to the CQC as soon as they happen.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because appropriate arrangements were not in place in relation to the recording of medicines.

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

There have been a number of safeguarding concerns reported to the CQC over the past 12 months that related to issues around medication processes failing to be carried out correctly which meant people had been put at risk as a result of these mistakes. The assistant manager told us they had improved their processes for checking medicines were administered correctly and documented accurately. We reviewed these processes and the records and found they all appeared to be in place and well documented. However, in practice we saw that staff had failed to apply the processes that were in the homes improvement policy for managing medicines . We saw the assistant manager had received medicines, for a person who was due to stay at the home, which had not been labelled with the name of the tablets, any details about the prescribed dose and not checked or noted how many tablets had been received. This meant that in the event of an emergency medical problem in the home staff would not be able to give any further information on the persons' medicines to hospital doctors or paramedics where healthcare concerns had arisen. This also meant there was a risk that not all medicines held in the home could be accounted for.

We also saw that medicines had been received by the home on another day we inspected and these were stored away in the locked cabinet in a room without being recorded onto the medical records that were kept for every person staying in the home. The member of staff in charge that day told us the medicines were not being administered at the time because the person had been taken into hospital. We noted that none of the tablets had been removed from any of the boxes. When we asked the member of staff in charge that day for the daily audit we saw this had not been completed and were told they did not have time to complete it yet.

It was evident from what the member of staff told us that even if the audit had been completed on time the medicines from the cabinet would not have been included. This meant staff had failed to check these as part of the daily audit process which meant people were still put at risk of misuse. Appropriate arrangements were therefore not in place in relation to the recording of medicines.

We reviewed the training records and saw that all members of staff who worked in the home had received medication training. When we spoke to the staff they were able to describe the processes and procedures for medications however in practice we saw parts of this had failed.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

Appropriate checks were undertaken before staff began work. There were effective recruitment and selection processes in place. The assistant manager told us that the home's policies and procedures for the recruitment of staff were followed for every post that had been recruited to.

Staff files were kept at a central office. We requested record checks for five of the staff working in the home and received confirmation that each person had completed job application forms disclosing their work history, provided appropriate forms of photo identification, job references had been obtained, and enhanced checks either with the Disclosure and Barring Service or the Criminal Records Bureau were undertaken as a part of the recruitment process.

Staff confirmed they had completed a thorough application process that involved an interview and reference checks before starting work.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

There was an ineffective complaints system. Comments and complaints people made were not responded to appropriately.

We have judged that this has a minor 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

When we asked to look at the complaints log, the assistant manager informed us there was no formal log or recording system and that complaints were recorded and filed in individual people's records. This meant there was no easy way for complaints to be reviewed and analysed for themes and to prevent the same issues arising.

We examined two records where we were aware that complaints had been made by the relatives of people who used the service. In both files we saw no information about the complaints. We saw no record of when the complaints had been reported, the nature of the complaint or any information about how the complaint was dealt with. One relative recently got in touch with us to inform us that they had still not had their complaint concluded since they raised it over three months ago. We saw no evidence of the complaint recorded on file or how this had progressed. The assistant manager was unaware of the complaint and was unable to tell us of any improvements made due to the complaint.

When we reviewed the complaints system we saw no evidence of learning taking place from any complaints. Staff were unable to demonstrate any learning from recent complaints and they were unaware of the complaints we had received. This meant people were put at risk of similar events reoccurring because no formal process took place for staff to understand the nature of complaints and how to prevent them from happening again.

Notification of other incidents ✖ Action needed

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was not meeting this standard.

People cannot be confident that all important events which affect their health, safety and welfare will be appropriately reported to us.

We have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We were informed by the local authority that there had been several safeguarding events that had been reported and were investigated under the multi agency policy for safeguarding vulnerable adults from abuse. The CQC had not been informed about the event or kept up to date about the investigations and any actions and outcomes that had been agreed.

Under the regulations of the Health & Social Care Act 2008 the service must keep us informed of all serious events. The purpose of this is so we can track incidents and monitor whether the service has made the correct choices when dealing with events that could have put people at risk of harm. A failure to do so could also result in people having their needs unmet.

We found that there was no guidance about statutory notifications available to staff. This meant that staff may not be aware of events we must be told about or the process to follow if they needed to report something to us.

The failure to report incidents in a timely manner and to the relevant agencies meant that the service had not followed safeguarding procedures correctly. This meant there was a risk that people using the service were not being fully protected from abuse or the risk of abuse.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have safe and effective processes in place for the recording and auditing of medicines (Regulation 13).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met: The service had failed to respond and deal with a complaint appropriately to the satisfaction of the person acting on behalf of a person that used the service. The service has not taken appropriate steps to share the response with staff members in the home (Regulation 19(2) (c)(d)).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 CQC (Registration) Regulations 2009** **Notification of other incidents**
	How the regulation was not being met:

This section is primarily information for the provider

	The registered person must notify the Care Quality Commission without delay of any events that effect the safety, and welfare of people who use services Regulation18(1)(2)(e)

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 07 April 2014.

CQC should be informed when compliance actions are complete.

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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