

Dimensions Somerset Sev Limited

Dimensions Somerset The Saplings

Inspection report

The Saplings Wiltons Orchard
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Date of inspection visit:
22 May 2018

Date of publication:
18 June 2018

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 22 May 2018 and was unannounced.

Dimensions Somerset The Saplings is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Saplings is registered to provide care and accommodation to up to seven people. The home specialises in the care of people who have learning disabilities and complex physical disabilities. All accommodation for people is on the ground floor and all areas are accessible to wheelchair users. At the time of the inspection seven people were living at the home.

The care home has been open a number of years and was previously owned and managed by Somerset County Council. This was the first inspection of the home since it was registered with Dimensions Somerset Sev Limited.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager in post, however at the time of this inspection the registered manager had been away from the home for a number of weeks and the home was being managed by the deputy manager. 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.

Improvements were needed to make sure the home was well led. The quality monitoring was not always effective in making sure that improvements to the service people received was implemented in a timely manner. Records relating to the safe running of the home and people's personal care were not always clear, up to date or correct. Information, such as care plans and the complaints policy was not always available to people in a format which met their individual needs.

Staff were not always following up to date guidance in relation to the safe storage and recording of medicines.

People were comfortable and relaxed with the staff who supported them. The provider had systems to minimise the risks of abuse to people and staff knew how to report concerns. Risk assessments were carried out to enable people to take part in activities and receive care safely.

Staff worked with other professionals to make sure people's care and support met their needs. Staff followed advice given and monitored people's well-being, although records relating to people's individual care were not always clear.

Staff knew how to support people who lacked the capacity to make decisions. People were supported to have choice and control over their lives and staff supported them in the least restrictive way possible. When people lacked capacity, decisions had been made on their behalf following current legislation.

People were cared for by staff who were kind and compassionate. Long term staff had built trusting relationships with people and tried to involve them in day to day activities according to people's abilities. People's physical needs were well managed and staff ensured people had opportunities for social stimulation.

The home was situated close to local facilities which enabled people to access community facilities such as shops, cafes and the park. At the time of the inspection people had limited access to transport due to issues with staff training.

We recommend that the provider ensures all staff are familiar with the current national guidelines for managing medicines in care homes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not totally safe.

People's medicines were not always stored and recorded in accordance with current national guidance.

Risk assessments were carried out to enable people to receive care and take part in activities with minimum risk to themselves and others.

People were supported by adequate numbers of staff because the provider used agency staff to cover vacancies.

Is the service effective?

Good 

The service was effective.

People were supported by staff who had received appropriate training to care for them.

People had their nutritional needs assessed and received meals in accordance with their needs.

People had access to a range of healthcare professionals to meet their needs.

Is the service caring?

Good 

The service was caring.

People were cared for by staff who were kind and compassionate.

Staff supported people to be involved in day to day decisions as far as they were able.

People's privacy was respected most of the time.

Is the service responsive?

Good 

The service was responsive.

People received care and support which was personalised to them because permanent staff knew them well.

People had opportunities to take part in some activities.

Is the service well-led?

The service was not always well led.

The provider's systems for monitoring and improving the service was not always effective in ensuring people received an improving service.

People lived in a home where staff did not always feel involved or supported by the provider but were committed to providing good quality care to people.

Requires Improvement 

Dimensions Somerset The Saplings

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 planned to check 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.

This inspection took place on 22 May 2018 and was unannounced. It was carried out by one adult social care inspector.

The provider had completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and other information we held about the service before the inspection visit.

People who lived at the home were unable to verbally express their views to us. We therefore used our observations of care and discussions with staff to help us form our judgements.

During the inspection we were able to observe care and interactions with all seven people who lived at the home. We spoke with eight members of staff. We looked at records which related to people's individual care and the running of the home. These included three care and support plans, medication administration records, health and safety records, records of staff training and records relating to quality monitoring.

Following the inspection we requested further information regarding quality monitoring and fire safety checks and this was forwarded to us in a timely manner.

Is the service safe?

Our findings

Improvements were needed to make sure the recording and storage of people's medicines was in accordance with current national guidelines.

Each person had their own secure medication cupboard. Each cabinet contained a thermometer and staff were asked to record the temperature of the cabinet each day. The recording sheet directed staff to 'take action if temperature outside the optimal range.' However the desired temperature was not specified and no staff spoken with knew what the optimal range should be.

There was also a fridge to store medicines and again staff were asked to record the temperature daily. On the day of the inspection staff had recorded the temperature of the fridge as 0.2 degrees. The correct temperature for the storage of medicines which require refrigeration is between 2 and 8 degrees. No action had been taken to correct the temperature. Storing medicines at incorrect temperatures can potentially place people at risk of receiving medicines that do not have maximum effectiveness.

The recording of medicines was not always in accordance with current national guidance. For example, one person had a medication administration record that had been hand written by staff. The entries had not been signed and witnessed by another member of staff to minimise the risk of entries being incorrectly written. There was a hand written entry for pain relief but this was also on the person's printed medication administration record. This potentially placed the person at risk of receiving twice the recommended daily dose.

Some people were prescribed medicines, such as pain relief, on an as required basis. In most cases there were no protocols in place to give staff details of when these should be administered. People who lived at the home would be unable to verbally request these medicines. Whilst most staff knew people well and said they would recognise if someone was in discomfort there were a number of agency staff and some new staff who may not be able to recognise people's non-verbal communication of pain. There was no guidance to show how or where prescribed creams or lotions should be applied. This meant there was a potential risk people would not receive medicine as prescribed or consistently.

The lack of guidance for the use of 'as required' medicines had been highlighted by the provider's quality monitoring systems in April 2018. However at the time of the inspection these had not all been completed.

We recommend that the provider ensures all staff are familiar with the current national guidelines for managing medicines in care homes.

There were some systems to ensure people's safety in an emergency situation such as a fire. Each person had a personal evacuation plan giving details of the support they would require if they needed to be evacuated from the building. A fire evacuation practice had been carried out in January this year. This helped staff to become familiar with how to safely evacuate people from the building in the event of a fire

The building was fitted with a fire detection system including alarms and emergency lighting. The fire log showed that fire alarms should be tested on a weekly basis and emergency lighting on a monthly basis. Staff confirmed that alarms were tested every Wednesday morning. However records we saw showed that the last time the alarms were tested was on 25 April 2018 and the last time the emergency lighting was tested was in October 2017. This was not in accordance with provider's policies. Following the inspection the deputy manager sent evidence to show that fire safety checks had been regularly carried out but these were not recorded in the fire log.

People required full support to move around and transfer from place to place. There was ceiling tracking fitted in bedrooms to enable people to be safely hoisted from their beds to the bathroom or their wheelchairs. There was also a mobile hoist. Lifting equipment had been tested to ensure it's safety. Staff had received training in how to safely move people using this equipment. We observed two staff support a person to move using a mechanical hoist. Staff were competent and gave reassurance to the person they were assisting.

On the day of the inspection there were adequate numbers of staff to meet people's needs and to keep them safe. People received individual attention and were able to go out on activities with staff support. Since the change in provider there had been some staff losses and agency staff were being used to make sure people were safely supported.

People looked relaxed and comfortable with the staff who supported them. Some people actively sought staff attention and others smiled and gestured with good humour when staff approached them.

Staff told us there had been a time when there was a lack of consistency in the agency staff working at the home. Agency staff were now being block booked which helped to provide stability for people. A number of staff commented on how much better they thought this was for people. One member of staff told us, "We expressed our concerns at a meeting and now we see the same agency. It is much better and the guys seem much more relaxed." An agency member of staff said they had shifts at the home booked into the future and felt part of the team.

People's care and support plans contained risk assessments to enable them to take part in activities and receive care with minimum risk to themselves and others. For example, one person's risk assessment showed they liked to spend time alone in the bath. To promote their choice, but maintain their safety, the risk assessment stated the person should be checked on every five minutes when they were in the bath. Other risk assessments showed the number of staff required to enable people to take part in activities such as swimming and using other community facilities.

People could be confident that any restrictive practices were only used after a full assessment of the person's needs and in their best interests. For example, care and support plans contained assessments regarding the use of bedrails and lap straps on wheelchairs. The assessments highlighted why equipment was needed to keep people safe.

Risks of abuse to people were minimised because the provider had systems and processes to minimise risks. New staff were well recruited and training was provided to make sure people received safe care. Staff said they had not been able to commence work until checks had been carried out to make sure they were safe to work with vulnerable people.

Staff had received training in safeguarding adults and knew how to recognise and report abuse. Staff spoken with felt they would recognise any changes in a person's behaviour which may indicate they were unhappy

about something. All staff said they would not hesitate to report any concerns and all felt that any worries they had would be taken seriously and action would be taken to protect people.

People were protected from the spread of infection because staff had received training regarding infection control. Staff had access to personal protective equipment such as disposable gloves and aprons and we saw these were used appropriately.

All incidents and accidents which occurred in the home were reported to the provider via an on line reporting system. This enabled the provider to monitor incidents and share any learning throughout the provider group.

Is the service effective?

Our findings

The Saplings provided appropriate accommodation for the people who lived there. All accommodation used by people was on the ground floor and bedrooms, communal areas and the garden could be accessed by people using wheelchairs. Staff had supported people to personalise their bedrooms which gave them an individual, homely feel. Staff said there was appropriate equipment to support people safely and effectively.

People enjoyed spending time in the kitchen when staff prepared drinks and meals. However the size and design of the kitchen did not promote participation. Most people used wheelchairs throughout the day but kitchen worktops were not accessible to enable people to take part in meal preparation. The kitchen was quite small which limited the ability of people to take part in activities with staff.

People were supported by staff who had received training to meet people's needs. New staff completed an induction programme which gave them the basic skills required to safely support people. One member of staff said, "The induction explained everything." Records were kept of all staff training and these showed that staff had completed the provider's mandatory training which included health and safety, moving and handling, safeguarding and infection control.

The provider has systems in place to assess staff competence to make sure any learning was put into practice. Once staff had completed medicines training a senior member of staff observed staff members administering medicines to make sure their practice was safe. They also carried out observations of staffs moving and handling practice to make sure they were competent in this area.

Staff knew people well and were able to tell us how people indicated they were consenting or refusing care and support. One member of staff said, "You get to know people and you know when they are ok with things and when they want to be left alone." During the inspection we saw that one person indicated they did not want staff support and staff respected their decision.

People's legal rights were protected because staff worked in accordance with The Mental Capacity Act 2005 (MCA) The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When a person lacks the mental capacity to make a particular decision, any made on their behalf must be in their best interests and the least restrictive option available. Staff had undertaken training in the mental capacity act and knew how to support people who were unable to make a decision for themselves. Care plans contained information about people's capacity to consent to areas of their care. Where people lacked the capacity to give consent best interests decisions had been made.

People can only be deprived of their liberty to receive care and treatment which is in their best interest and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS). Where people required this level of protection the registered manager had made applications to the appropriate authority.

Each person had a care and support plan which was personalised to them. These plans set out people's needs and how they would be met. They also showed how risks would be minimised. Although care and support plans gave information regarding people's needs there was limited information about their likes or dislikes.

Information about people was spread over three files which made them difficult to follow and in some places contradictory. For example, one person's night care plan stated they needed to be assisted by staff to turn themselves regularly to reduce the risks of pressure damage to their skin. However in another folder it stated that staff needed to change the position of the bed twice during the night, not reposition the person.

Action taken when health concerns were identified was not clearly recorded which meant there was a potential risk that people would not receive the support they required. One person's care plan showed they had lost a significant amount of weight and there was no recorded rationale for this. Neither was there any follow on action to say what had been done to investigate this weight loss. In another person's care file, a member of staff had recorded that the person had possible pressure damage and needed to be seen by a district nurse. The file did not give information about what action had been taken as this was recorded elsewhere.

At the time of the inspection the staff were in the process of up-dating people's personal files in accordance with the new provider's policies. The provider had also identified that, where appropriate, people's personal representatives should be involved in the review of people's needs.

People had access to health and social care professionals according to their individual needs. People's personal files showed people attended appointments with GPs, dentists and hospital specialists. Each person had a health action plan which included a hospital passport. This helped to make sure other professionals would have the information they required if the person was admitted to hospital.

Some elements of people's care plans had been written in partnership with other professionals, such as occupational therapists and speech and language therapists. Staff spoken with had a good knowledge of recommendations that had been made by other professionals and worked in accordance with advice given. This helped to make sure people received their care and support in line with professional guidance.

People received meals in accordance with their known likes and dislikes. Some people were able to make simple choices and at lunch time we saw a person being shown a choice of two things and they able to specify which they wanted. Where people required staff assistance to eat their meal this was provided in a dignified and unhurried way. People looked happy with the food provided to them at lunchtime.

Some people's nutritional needs had been assessed by speech and language therapists who had created individual care plans for them. Staff followed the recommendation made. For example, one person's care plan stated the consistency which meals and drinks should be served at. At lunch time we saw the person received an appropriate meal and drink.

Is the service caring?

Our findings

People were cared for by staff who were kind and caring. Staff showed patience and compassion when supporting people. People looked calm and relaxed with staff who supported them. Some people actively sought staff attention and we heard staff sharing good humoured banter with people who smiled and laughed in response.

Some staff had worked at the home for a number of years and had built trusting relationships with people who lived there. One member of staff said, "I sort of think about the folks here as family." Staff spoke about people who lived at the home very affectionately. When asked what was the best thing about their job all staff said it was the people they worked with. One member of staff said, "It really is a lovely place and that's because of the service users."

People had opportunities to spend time with staff on a one to one basis which helped to promote social interaction. One member of staff said, "We try to do something with everyone every day." Another member of staff told us, "Most people can't actually speak to you but they certainly communicate. People here always seem happy. When they smile at you, you know you are getting it right and it makes you feel special."

Staff spent time with people making sure everyone was valued and was as involved as they were able to be. When a member of staff went to the kitchen to make drinks for two people they took the people with them so they felt included. One member of staff told us how they tried to get people involved in household chores to give them ownership of their home. They told us people got involved in day to day cleaning, painting fence panels in the garden and washing the mini-bus.

People and their representatives were not involved in writing or reviewing their care plans. However the quality monitoring at the home had identified this and had an action point to contact people's families or representatives to involve them in future reviews.

Where people had relatives staff helped them to keep in touch. Staff told us one person's family visited them and they helped another person to meet their relative outside the home. Some people regularly attended a day centre which enabled them to mix with people outside the home.

Staff respected people's privacy and dignity and ensured all personal care was provided in the privacy of people's bedrooms and bathrooms. When one person required a change of clothing we saw staff discreetly took them to their bedroom to assist them.

The home had both male and female staff which enabled people to make a choice about the gender of the staff who helped them with personal care. One member of staff said, "[Person's name] definitely prefers female staff so we make sure they have that."

During the inspection we noted all bedroom doors, which led off the main lounge area, were left open throughout the day. People were not in their rooms and some people had gone out. This meant people's

personal possessions were on display to anyone visiting the home. There was no rationale for this in people's care plans and no information to show how people were given a choice about this practice.

Is the service responsive?

Our findings

People received care and support which was personalised to their needs and abilities. The personal files we looked at contained life histories of the person and their experiences before they moved into the home. This gave staff some insight into what was important to people.

There was no recorded information regarding people's current preferred daily routines although staff spoken with had a good knowledge of each individual. Staff were able to tell us about what time people liked to get up and how they chose to spend their day. As the home used a number of agency staff, and new staff were being recruited, recorded information about people's preferences, cultural needs and lifestyle choices may have been useful to make sure people received support in accordance with their preferences.

Staff respected people's independence and their right to determine how they lived. For example, one person chose not to use a wheelchair in the house despite poor mobility. Staff made sure this person had a walking aid with them which helped to minimise the risks of falls but enabled them to move around independently.

Some people had lived at the home for a number of years and their needs had changed as they aged. Staff had responded to changes in people's needs by ensuring appropriate professionals were involved in their care to support their changing needs. For example, some people were regularly visited by community nurses to monitor their physical health. Staff told us about one person who they supported with regular exercises to help them to maintain strength in their limbs.

At the time of the inspection no one at the home was receiving end of life care. Staff said they would work with other professionals if this situation arose.

People had access to activities at the home and some people attended a local day centre. One member of staff said they aimed to make sure everyone had access to some form of activity every day. The home had a mini bus but the use of this for trips out was limited by the number of staff who had received appropriate training to drive it. One member of staff told us that over the past 12 months activities had been "Seriously curtailed" but they had tried to keep as many things going as possible.

The home was situated within walking distance of the town centre and a large park which meant people had opportunities to go out even when there was no driver available. On the day of the inspection a mini bus driver was available and some people went swimming. Other people went shopping in the town with staff.

The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. The majority of people who lived at the home had no verbal communication. Assessments had been carried out by speech and language therapists to promote good communication for people. Each person had a communication profile in their care and support plans which gave staff some indication of how people communicated and what certain sounds and gestures meant for that person.

Staff told us they used a variety of methods to communicate with people, which included verbal communication, some signing and some objects of reference. During the inspection we saw staff showing people things to enable them to make choices through gestures or eye pointing. The staff who had worked at the home for a long time were able to tell us how each person communicated.

The provider had a complaints policy to handle formal complaints. This policy was not in a format that could be easily understood by people who lived at the home and staff spoken with said they did not think the policy was available in different formats. Some staff spoken with said they were confident they would recognise any changes in behaviour or mood which may indicate a person was unhappy. One member of staff said "Obviously we would do everything we could to sort out anything that was upsetting someone."

Is the service well-led?

Our findings

Improvements were needed to make sure the home was well led. Although quality monitoring was carried out by the registered manager and the provider this had not always ensured improvements needed were carried out in a timely manner. The provider had systems in place to monitor quality and produced action plans to show how improvements could be made. These action plans were not effectively monitored to make sure people were receiving an improving service.

A number of records were not up to date, such as the fire log. Although tests had been carried out to ensure the safety of people there was no clear record of this. Other records had not been completed, or had been completed incorrectly, such as protocols for the administration of 'as required' medication and hand written medication administration records. People's personal information was spread across a range of folders making it difficult to see what actions had been taken when concerns were identified. This demonstrated a lack of management oversight which would have enabled them to quickly identify and rectify issues before they posed a risk to people.

All accidents and incidents which occurred in the home were recorded on line and submitted to the provider to enable them to be monitored. However staff said once records had been submitted they did not have access to them. This meant that on-site staff were unable to identify patterns or trends in accidents and incidents which may require further investigation or changes to practice.

People were cared for by a staff team who were committed to ensuring people received a good standard of care. However staff did not always feel supported by the provider. One member of staff said, "I would say the things missing in this home are leadership and valuing staff." Another member of staff said, "I think the service users are well looked after but as support staff we have no contact with the provider and we would like to see them more."

There were limited ways for people, staff and other stakeholders to share their views. Staff said recently there had been some improvements in this area. Some staff meetings had been held and others were planned. There had also been some one to one supervision sessions for staff which enabled them to share their views and discuss their practice. The home's action plan stated that they would begin to involve people and their representatives in reviewing and writing their care plans.

There was a registered manager in post. However at the time of this inspection the registered manager had been away from the home for a number of weeks and the home was being managed by the deputy manager. 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.

The registered manager and provider had not always been pro-active in identifying needs. For example, although a new mini-bus had been provided to the home, the provider had not ensured there were

adequate numbers of staff who could safely take people out. This had resulted in people having limited access to transport that may enhance their social and leisure opportunities.

Where appropriate the staff worked in partnership to make sure people received appropriate care and treatment. Staff told us they had good relationships with professionals and we saw that some care plans had been written by healthcare professionals. This helped to make sure that people received their care and support in accordance with up to date good practice guidelines.

The provider had notified the Care Quality Commission of all reportable incidents in accordance with their legal responsibilities.