Dimensions (UK) Limited

Dimensions 1-2 Westbury Way

Inspection report

1 Westbury Way
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Hampshire
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Dimensions 1-2 Westbury Way is a residential care home providing the regulated activity of accommodation and personal care to six people with a learning disability.

Although the location is registered as a care home, the building from which the location is operated is separately owned by a housing association who are responsible for its maintenance .

The service which is located in a residential street, comprises of two linked bungalows, each of which has three bedrooms, a kitchen, dining room, lounge, bathroom and cloakroom.

People's experience of using this service and what we found
We saw there were a range of maintenance issues with the property, some of which had been present for a significant period of time, which had negatively impacted upon people's safety and quality of life. The poor condition of the property had negatively impacted staff's ability to protect people from the risk of catching COVID-19. The provider's processes had not been used effectively to escalate issues when the housing association failed to complete the required repairs in a timely manner. Notifications had not been submitted to CQC as required. The provider took immediate action to address these issues when we spoke with them after the site visit.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of the key questions safe and well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of right support, right care, right culture. Actions taken to ensure people's right to live in a home which was fit for purpose and well-maintained had not been effective. The provider once aware of the extent of the issues, took immediate action and devised an action plan to address this for people and ensured the required works were completed.

Potential risks to people related to their care had been identified, assessed and managed. There were sufficient staff for the service. The provider had taken all practicable measures to staff the service. There were robust recruitment processes. Processes were in place to safeguard people from the risk of abuse. People received their medicines safely from trained staff.

The provider had a clear vision for delivery of the service and promoted an open culture. They acted with integrity and were immediately responsive to our feedback. Relatives and staff felt the service was well-led and that they could speak with the registered manager. Stakeholders provided positive feedback on the

service,

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 30 June 2017).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns. The inspection was prompted in part due to concerns about a recent outbreak of COVID-19. A decision was made for us to inspect and examine those risks.

We inspected and found there were also concerns with the environment, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dimensions 1-2 Westbury Way on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to premises, governance and notifications at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an updated action plan from the provider to understand what they will continue to do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Dimensions 1-2 Westbury Way

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by an inspector.

Service and service type
Dimensions 1-2 Westbury Way is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Dimensions 1-2 Westbury Way is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
We gave a short period notice of the inspection because some of the people using the service may have been unsettled by an unannounced visit.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information

providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We sought feedback from the local authority and a health care professional. We used all this information to plan our inspection.

During the inspection
People living at the service could not speak with us about their experiences, so we observed people's care and staff interactions with them in the communal areas of the service. During the site visit the registered manager was not available, we spoke with three care staff.

After the inspection
Following the site visit we spoke with two people's relatives. We also spoke with the registered manager and the regional managing director and we contacted the nominated individual about our findings. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We requested from the provider a range of written information about the service which we reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● We identified a range of maintenance issues with the building, some of which had been present for a significant amount of time, which had negatively impacted people's care and safety.

● We saw water leaking from the loft through the ceiling, directly through a fire alarm. Although staff told us an electrician had checked the safety of the fire alarm, this issue had been reported to the housing association in December 2021 and still needed to be addressed. There was no water supply to one of the location's two baths and to the hand basin in one of the two toilets. In one of the home's two kitchens, the hand basin tap was broken. In a toilet, tiles were missing or broken and a panel was loosely fitted which risked people gaining access to the pipes located behind. There had been intermittent issues with the heating for the service. Staff had used plug in heaters when the heating had failed, which lacked safety covers.

● In one kitchen the floor was so uneven, the fridge door could not fully open and the uneven floor in the dining room was a trip hazard. A washing machine was located in the middle of one kitchen, instead of the utility where it should have been, which meant people and staff had to walk around it. In both kitchens some door cupboards and drawer facings were missing, and in one, cleaning materials were visible and accessible. The fence was missing outside one of the kitchen windows, so the blind had to be pulled for privacy. A number of fence panels were missing from the perimeter of the building, leaving the garden open.

● The registered manager had since February 2021 repeatedly raised the above issues with the housing association who owned the property and were responsible for the maintenance and upkeep of the building. In September 2021 they had also approached the environmental health department.

● Following the site visit CQC raised a safeguarding with the local authority about the condition of the property and the associated risks to people.

The failure to ensure premises used by the provider were properly maintained and secure and to ensure required improvements were completed without delay was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the site visit, CQC spoke with the provider who had not been made aware of the full extent of the issues. They took swift action and immediately provided CQC with an action plan and updates. They authorised their own maintenance team to address those issues which were immediately rectifiable. They have either competed or arranged for all of the works to be completed apart from the flooring which requires further investigation.

● Records confirmed hoists and the electric baths had been serviced as required. All relevant safety checks

had been completed in relation to electrics, gas, water and fire.
● The provider had processes in place to ensure potential risks to people were identified, assessed and appropriate actions were taken to address them. People had a range of risk assessments in place. People's risk assessments referenced any professional guidance staff needed to be aware of and any specific training staff needed to support the person safely. Staff spoken with understood the potential risks to individuals and how these were to be managed. People's relatives told us their loved ones were safe in the care of staff.

Preventing and controlling infection
● All six people were sharing the one working bath. People in one bungalow had to use the toilet in the cloakroom and then go through two doors to access a working hand basin in the bathroom. Staff and one person in one bungalow were sharing the staff toilet in the morning, as the bathroom was used for people to bathe. One kitchen lacked a working hand basin for staff to wash their hands prior to food preparation. We observed staff carry a red linen bag which are used for soiled laundry into a kitchen where they loaded the washing machine which was a hygiene risk. There were no locks on the external clinical waste bins, to prevent access.
● Staff's ability to cohort people during the recent COVID-19 outbreak was hampered by the lack of water to one of the baths. The poor physical state of the environment and the lack of fully functioning bathing and hand washing facilities within each bungalow meant the risk of people and staff contracting an infection had increased. All six people and most staff had recently caught COVID-19.
● The registered manager was not aware of the required cleaning products for use during a COVID-19 outbreak.

The failure to ensure appropriate standards of hygiene in relation to the premises or to ensure the correct cleaning products were used was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the site visit, CQC spoke with the provider who had not been made aware of the full extent of the issues. They took swift action and provided CQC with an action plan and updates. They authorised their own maintenance team to address those issues which were immediately rectifiable. They have since informed us all of the issues with the water supply in the premises have been addressed for people and the correct cleaning products have been purchased.

Staff had received relevant infection control training and followed guidance for the use of personal protective equipment. Processes were in place to protect visitors from the risk of acquiring an infection.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

Staffing and recruitment
● Records showed it had not been possible to staff all shifts at the level commissioned for two weeks during the COVID-19 outbreak at the service. However, there was no evidence people's safety had been compromised. The registered manager told us three out of the 17 full-time posts were vacant and these hours were covered by permanent staff volunteering to work additional shifts and regular agency staff. The

provider had an ongoing recruitment programme and had increased staff's pay and introduced a new starter programme to welcome and support new staff. A relative told us staff regularly drove their loved one to visit them at home. Another relative said, "A lot of the staff have changed but others have been there for years." The provider had taken all reasonable measures to recruit and retain staff.

● The provider operated robust recruitment processes. Their staff pre-employment recruitment checks included a Disclosure and Barring Service (DBS) check and all of the required pre-employment checks upon staff's suitability for their role. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse

● People had risk assessments in place which identified the potential risks to them from abuse and how these were to be managed. They were also provided with an easy read guide to safeguarding and complaints. Relatives said they felt their loved ones were well cared for and safe with staff.

● Staff had all undertaken the provider's safeguarding training and had access to the provider's safeguarding policy. Staff spoken with understood their role in relation to safeguarding and the types of abuse. Records showed staff had reported incidents to the local safeguarding team as required.

Using medicines safely

● We found the keys to two people's medicine cabinets were stored in their bedrooms, which could have allowed unauthorised access. We brought this to the attention of staff who took immediate action.

● People received their medicines from trained and competent staff. Processes were in place to guide staff when they administered people's medicines which they recorded. People had medication reviews and a person's medicine was being reduced in accordance with good practice guidance. Medicines were stored at the correct temperature. Records showed staff had reported medicine incidents and relevant actions had been taken to prevent the risk of repetition.

Learning lessons when things go wrong

● Processes were in place to record and investigate incidents. The incident log showed staff had reported incidents as required for review and to enable any required actions to be taken. Following a fall, a person had been referred to a health care professional for assessment to minimise the risk of repetition. Processes were in place to enable staff to reflect upon incidents.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care

● The issues with the building were extensive and some of the required repairs were long-standing. Records showed the registered manager and staff had logged numerous maintenance issues with the housing association since February 2021. A health and safety audit completed by the registered manager in September 2021 and an audit completed by the providers quality and compliance team in January 2022, both noted maintenance issues had been reported to the housing association. However, the lack of effective action by the housing association to address the maintenance issues had not been escalated fully and effectively to the provider's senior management team for further action. People were at risk from their environment and all of them and most staff had caught COVID-19. Effective actions were not taken to escalate the issues internally.

● Although the registered manager told us they completed their own visual checks of the cleanliness of the service, they were not aware of the provider's infection prevention and control audit which they should have used to audit the infection prevention and control practices at the service. They informed us they would immediately start to use this audit tool.

The failure to take measures to remove the risks associated with the premises within a timescale that reflected the level of risk and its impact upon people or to ensure the information identified within audits about the maintenance issues were escalated was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the site visit, CQC spoke with the provider who had not been made aware of the full extent of the issues. They took swift action and provided CQC with an action plan and updates about progress. They also reviewed what had happened and took immediate measures to prevent the risk of repetition. A check was completed of a second property owned by the same housing association. They also introduced additional measures to ensure any outstanding maintenance issues were escalated to senior management in a timely manner.

● Processes were in place to audit people's medicines and records showed these had been effective at identifying areas for improvement.

●The registered manager had failed to inform CQC as required that physical damage to the property they used was having a detrimental effect on the care and treatment provided to people. They also failed to

notify CQC of two incidents they reported to the local authority under safeguarding procedures and the outcome of an application made to the local authority to authorise a Deprivation of Liberty Safeguards for a person.

The failure to inform CQC of notifiable incidents without delay was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

After the site visit, the notifications were submitted.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People's relatives told us they were kept updated and informed of any incidents, which records confirmed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had clear values which included respect, courage, ambition and partnership and integrity. There were examples for staff about how to apply these in practice when supporting people. The provider acted with integrity and was immediately responsive to our feedback.

● The registered manager managed two locations, with the support of a deputy manager. They told us they visited the service twice a week and provided staff with telephone support. They were supported in their role through regular supervisions, registered manager monthly meetings and an annual appraisal.

● Relatives said the service was well-managed and staff reported, "It is a good place to work." Staff had received a bonus when supporting people with COVID-19 and there was a staff recognition scheme. There was also a bonus scheme for staff who recruited a friend to work for the service. Staff had access to mental health first aiders, to support them with their mental well-being and an employee assistance programme where they could seek support if required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us they were regularly updated about their loved one's well-being. There were regular staff meetings where staff could raise issues. Surveys had been completed with people and staff within the last year.

● People used the local shops and amenities. The registered manager told us in order to attract new staff, the service had sponsored a local children's football team, to increase awareness of the service locally.

Working in partnership with others

● The registered manager had shared information about the maintenance issues with the local environmental health department. They had not considered using safeguarding processes when the housing association failed in their duty to ensure the required repairs were completed for people's safety, which they could have done.

● Stakeholders told us they had not experienced any issues with the service or the standard of care provided to people.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents There had been a failure to inform CQC of notifiable incidents without delay. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment There had been a failure to ensure premises used by the provider were properly maintained and secure and to ensure required improvements were completed without delay. Regulation 15 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There had been a failure to take measures to remove the risks associated with the premises within a timescale that reflected the level of risk and its impact upon people or to ensure the information identified within audits about the maintenance issues were escalated. Regulation 17 (1).