Care Quality Commission

Dimensions Somerset Sev Limited

Dimensions Somerset Frome Domiciliary Care Office

Inspection report

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Date of inspection visit:
14 September 2020
16 September 2020
21 September 2020
23 September 2020

Date of publication:
21 December 2020

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Dimensions Somerset Frome Domiciliary Care Office is a domiciliary care agency. It provides personal care for older and younger people with learning disabilities and/or autism in their homes or flats in the community. At the time of the inspection 94 people were receiving support.

Some of the people lived in one of the 12 supported living services whilst other lived in shared accommodation or individual homes and flats. Many of the households had multiple occupancy of over three people with shared living spaces. Many of the people required 24-hour support and this changed for some during the COVID-19 pandemic.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
The service was not well led. Quality assurance systems did not effectively monitor each household and drive improvement. When concerns were identified they had not always been rectified. Some concerns found during the inspection had not been identified by the provider's quality assurance systems.

People were not always kept safe from risks which could lead to potential harm. Care plans were mixed and missing key information or details known by staff. When people's needs changed, care plans had not always been updated to reflect this.

There was a high turnover of senior staff and staff at each household leading to inconsistencies of support and systems. Agency staff were used and during the COVID-19 pandemic staff had been relocated from temporarily closed day services.

People told us they were safe or displayed they were comfortable around staff. Relatives had mixed views about the care and support their family members received. Staff had good understanding of how to recognise potential abuse. However, they lacked knowledge of external places they could report concerns.

The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. When households under the registration were not fully meeting the principles we heard of plans to find more suitable living arrangements and staff training. The provider had a model of support and care placing people at the centre of all the choices and support they received. Relatives confirmed they were involved in most decisions when people were less able to express choices themselves. Staff told us of the provider's ethos where people's privacy, dignity, human rights and choice were central to their daily lives. However, the COVID-19 pandemic had placed some limitations on practices because they were trying to follow government guidance to keep people safe.

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

Rating at last inspection
The last rating for this service was good (published 11 August 2018).

Why we inspected
We received concerns in relation to the management of the service and peoples' safety. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. This is to provide assurance that the households visited, and the provider can respond to coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well Led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dimensions Somerset Frome Domiciliary Care Office on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to keeping people safe from potential harm and poor governance at this inspection.

You can read the end of this report for the action we took. This includes asking for an action plan and placing some conditions on their registration to drive improvement.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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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 specific legal requirements and regulations associated with the Act within the safe and well-led key questions. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by three inspectors. One inspector completed the full inspection including visits to services, virtual visits and reviewing information. Virtual visits involved a video call to speak with people and staff who lived and worked in a household. Two inspectors completed reviewing information and virtual visits when required.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses, flats and specialist housing.

This service provides care and support to some of the people living in one of 12 'supported living' settings, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

The registered manager was also the operations director and oversaw locality managers and better practice leads who help to run each household under the registration.

Notice of inspection
We gave a short period notice of the inspection because some of the people using the service could not consent to a home visit from an inspector. This meant that we had to arrange for a 'best interests' decision about this.

Inspection activity started on 14 September 2020 and ended on 7 October 2020. We incorporated virtual catch ups (with the use of video calls) with the registered manager on 22 September, 1 and 7 October 2020 instead of attending the office due to the COVID-19 pandemic. We completed visits to supported living services on 14, 16, 21 and 23 September 2020. Four supported living services were virtually visited on 22, 23 and 25 September 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who worked with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 18 people who used the service, 25 relatives and one health professional. Two relatives contacted us in writing. We spoke with 33 staff from various levels including the registered manager, locality managers, better practice leads and care staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also carried out informal observations whilst in households or completing virtual visits.

We reviewed a range of records both on and off site. This included eight people's care records and multiple medication records. We looked at recruitment records and a variety of records relating to the management of the service including policies, procedures and training records.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated 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

● Most staff knew people very well. However, care plans were not always reflective of best practice or people's current needs. Therefore, newer staff and agency staff had nowhere to reference in relation to risks. The inspection took place during the COVID 19 pandemic which presented the risk of staff needing to isolate at short notice. There was also new staff met during the inspection and therefore it was especially important that care plans were current and contained up to date guidance to reflect people's risks and needs.

● People with epilepsy were at risk of potential harm by not receiving care in line with their assessed needs. Care plans were not always completed in line with current best practice. For example, one person's epilepsy risk assessment had not been reviewed by health professionals since 2017 and they had recently had five recorded seizures and one potential seizure. Another person had a type of seizure which was mentioned in one part of their care plan and not in the seizure plan. Staff confirmed the person's relative stated this type of seizure was known about.

● People who had changing health needs were not always having care plans and guidance for staff updated. One person with complex health needs had recently had a medicine review from a health professional. However, their seizure plan had not been updated in line with these changes to reflect their current needs. Additionally, other parts of their care plan contained out of date guidance in relation to another health issue. Staff who knew them well appeared to have knowledge of these changes, so they had not come to harm. New staff and agency staff would have inconsistent references and guidance detailing the person's assessed needs placing them at risk.

● Another person had declining health; however, their current needs and risks were not reflected in their care plan. Staff appeared to have some knowledge of the person's needs. However, this was not always in line with the newly identified health needs. There was no guidance for staff to follow in line with suggestions made by a health professional although other health professionals had been contacted. One of the suggestions had been identified during a review in April 2020. However, little appeared to have changed in the person's care plan and staff had minimal understanding or training.

● Identified risks had not always been clearly recorded which left potential risks for it not being followed correctly. For example, one person required restricted fluids in line with their health conditions. In July 2020, it had been identified their care plan did not reflect their needs in relation to this. Their 'support for living plan' and risks This was kept in a separate folder, so key information could be missed by a new member of staff or agency staff.

We found no evidence that people had been harmed. However, risks were either not assessed or ways to mitigate them in place. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People who had behaviours which could challenge when they were anxious had clear plans in place. These were usually in the format of a team approach. They clearly identified triggers and proactive actions staff could take to minimise the person's anxiety. Staff were aware of these behaviours and could seek advice from a specialist behaviour team.
● The management of each household, with the support of the provider, had been evaluating the compatibility of each person living at a specific household. Actions were being taken to try and resolve some of these compatibility issues which had been identified.

Preventing and controlling infection
● People were not always being kept safe from the staff using Personal Protective Equipment (PPE) effectively and safely. During visits to households the inspector witnessed a few occasions where staff were tired and forgot the appropriate use. For example, in one household there were two occasions masks were not worn in line with best practice. In another household, staff were forgetting the sequence for putting on and taking off PPE. The registered manager was informed, and they stated refresher training would be completed. Reminder posters were placed in all households for reference about sequence of putting on and taking off PPE.
● The provider was preventing visitors from catching and spreading infections. Every household we visited we had our temperature checked and details recorded. People we spoke with confirmed temperatures were always taken of visitors. One relative said, "I wear PPE inside as [person] cannot go out as she is very poorly."
● Staff followed social distancing rules and shielding in the households. Risk assessments had been completed for each household about the level of PPE required by staff in line with people's understanding of social distancing.
● People who had visited family or had hospital stays mainly followed isolation requirements to keep others safe. On one occasion a person had not followed these rules and action was taken to try and keep people safe.
● The management of each household had carefully thought about the best way to promote hygiene practices. Staff had clear areas designated for putting on and taking off PPE. Sometimes they had to adapt to the layout of the household.
● The provider had clear systems in place should an outbreak occur. Each household had an individual risk assessment in relation to this.
● The provider had been regularly updating their policies and procedures in line with government changes. This was communicated to managers and staff through regular emails with updates and news about the COVID-19 pandemic.
● We have also signposted the provider to resources to develop their approach.
Using medicines safely
● People were supported to take their medicines in line with current guidance. Staff knew people's preferences which was important as not everybody could communicate verbally.
● Relatives told us, "[Name] needs medicine and the staff organise it" and, "The staff are qualified and give it on time."
● Medicine was stored in secure cupboards in people's bedrooms. The temperature of the cupboards was monitored to ensure medicine continued to be safe to use.
● However, there were occasions when the provider's own policies and procedures were not being followed. For example, protocols for 'as required' medicines with variable dose options were not clear. Also, topical creams and liquids did not always have the opening date or new expiry date recorded on the bottle. We raised concerns with the management of each household who assured us they would rectify the issues.

Staffing and recruitment
● People thought there were enough staff supporting them and they liked them. Comments included, "Just

right" and, "Yes" when asked if there were enough staff. Other people smiled or nodded.
● Relatives had mixed opinions about staffing at the households their family member lived. Some felt there were enough whilst others did not. Some relatives said, "The staff have been consistent in lockdown", "When I visit, I think there are plenty of staff" and, "There are lots of staff. The staff are nice to [name]."
● However, concerns were raised about the turnover of staff leading to the consistency of care people received. Comments included, "There was a shuffle round the other day" and, "I do not always think there is enough staff. There is not enough consistency." One relative gave examples of how this had a negative impact on the support their family member received. Following the inspection, the provider told us about some positive action they had taken to recruit staff to households under the registration.
● Some staff and relatives told us there was still a high use of agency staff in some households. We saw this in one of the households. Relatives told us, "We believe over the weekend there is agency staff, but the provider is working on getting all permanent staff." and, "There can be a lot of agency staff and communication becomes a key issue." Following the inspection, the provider told us there was planned use of regular agency to provide consistency and continuity to people.
● During visits to households we found agency staff were being used. Staff had been relocated from the temporarily closed day services in some households to provide consistency for people during the COVID-19 pandemic. There was also a high turnover in senior staff at the individual households under the registration. We found new and acting senior staff at homes. Following the inspection, the provider told us that most new senior staff turnover was down to internal transfers of experienced staff. The provider also told us some staffing was determined by the packages they had agreed with the local authority. They told us systems were in place to support people and relatives if they were concerned about this.
● Recruitment systems were in place to ensure checks were completed prior to staff working with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
● People told us they were safe and appeared comfortable in the presence of staff. One person said, "Lovely staff and they are really nice. You can have a laugh. They can help you and are very professional." Other people nodded, put thumbs up or smiled when we asked if they felt safe. However, one person told us they felt unsafe because of some of the people they lived with. The registered manager provided some reassurance that this was being managed.
● Relatives had more mixed views about how safe people were. Some said, "Oh yes, [name] is safe. There is always someone around to help" and, "I am happy with the care that is given to [name]. I think [name] is very safe in the care of the staff." Others indicated there had been issues or there were still issues. One relative made it clear it depended upon which staff were working as to whether their family member was safe. Another relative said, "I do not think staff stay long enough."
● Staff had a good understanding of how to recognise potential abuse. They knew signs to look out for if a person had limited verbal communication. Staff knew who they could raise concerns to internally and felt something would be done. However, staff had limited knowledge about external bodies they could report concerns to who provide additional monitoring. We raised this with the registered manager who assured us they would look into this.

Learning lessons when things go wrong
● The provider and management were demonstrating that when some things went wrong, they had an ethos to learn from mistakes. For example, the provider had identified a rise in medicine errors. In response they had outsourced an external provider to make improvements. This included implementing new training for managers and staff and reviewing all the systems used. One relative said, "On one occasion the medicines were given wrongly, and they were quick to let me know and apologised."
● However, this was not consistently applied across all households and to all situations. Action plans

sometimes lacked ownership and deadlines of when improvements would be made. Some relatives told us about actions which should have been followed up and were not.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality or consistent care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
● The service was not well led. Systems to manage quality assurance were not effective to ensure people were kept safe from unnecessary risks. Recent phrases from the provider's own quality and compliance team said things like, "The monitoring of quality and compliance in the home are not regular or effective… Shortfalls identified in this review had been raised in these audits, but not resolved." and, "We were concerned that there were shortfalls in the Safe domain regarding risk management and health and safety equipment, but these had not been picked up by operational quality assurance processes."
● Action plans had been created following quality reviews. These sometimes had no ownership or deadlines about when they were meant to be completed including some significant concerns of potential risk. For example, in one household people with specific health risks had actions identified required to mitigate risk, these had no ownership or completion date on the provider's 'Continuous development plan'. This showed there was no effective system to close the audit cycle and protect people from unsafe or inappropriate care and support.
● Identified concerns were not always being resolved. For example, in July 2020, a quality review in one household identified issues with a person's health needs that were not reflected in their care plan. This was still the case during our inspection. There had been a change in management at the home. Another audit identified in April 2020 work would be put in place around end of life care planning. This had not occurred for one person nearing the end of their life. A third internal review from May 2020 stated, "A number of the concerns raised during this review have been identified as requiring action on the Service Improvement Plan reviewed in February 2020." This did not evidence that provider level oversight was robust or effective.
● Internal compliance systems had identified that some services had declined in quality and safety over time.
● Concerns found on the inspection were not always being identified by the provider. For example, some medicine management issues such as protocols for variable dose 'as required' medicine not having accurate protocols. Also, epilepsy plans were not always reflecting up to date knowledge of a person's seizure type or medication changes. This did not evidence an effective and robust system to monitor the health, safety and welfare of people was in operation and could lead to people suffering avoidable harm.
● The registered manager had a reliance on other parts of the organisation helping them to monitor the services under their registration. For example, they told us, "I meet with key internal partners to review data for each household as part of the quality assurance process." They also informed us 'performance coaches'

will complete visits and validate information then report back. During the COVID-19 pandemic minimal visits had occurred by senior staff on site.

● The provider was moving towards a culture of learning and improving care. However, due to the COVID-19 pandemic and changes in management at households, there was a lack of oversight to ensure improvements had occurred. Some households had not been visited since the beginning of 2020 despite there being an internal rating of "Not meeting expectations" or "Partly meeting expectations". One part of the registration had no quality and compliance visit since 2017. The registered manager and staff informed us this had recently started to change as new systems were put in place.

We found no evidence that people had been harmed. However, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had started the process of embedding a system called "Active Support". This promoted the person being at the centre of their care and supported to achieve as much independence as possible. Staff were aware of this ethos and were learning how to appropriately support people to achieve this.

● The registered manager had created opportunities for senior staff in households to share good practice and learn from each other. They also promoted learning sessions on best practice topics such as resilience and closed cultures.

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

● The provider and registered manager were aware of their legal responsibilities around duty of candour. However, it was not always applied consistently, and we heard an example of it not being effective with a relative.

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

● People were engaged and involved in the running of their care as much as possible. Some people told us how they helped to write their care plans

● Most relatives felt they were engaged and involved. The changes in staff made this difficult for some of them. Positive comments included, "I think they would act on any changes suggested"," I am definitely involved in the care of [name]" and, "The staff are very good and keep me informed." However, a few relatives felt they were not engaged as much. For example, one relative was struggling to get adequate responses. Another relative said, "Information shared with [name's] family is not always to the point and relevant."

● Staff generally felt they were listened to and supported by the provider. An overwhelming majority felt that the provider had done a fantastic job of supporting them during the COVID-19 pandemic. This had included through regular communication, meetings and well-being support.

Working in partnership with others

● Most households had developed positive relationships with other health and social care professionals. These had ensured that people's needs could be reviewed even during the pandemic.

● Prior to the COVID-19 pandemic staff and the management had developed strong links with the community. These helped at the beginning of the pandemic for people to get their needs met.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm.

The enforcement action we took:

We added conditions to the provider's registration to help drive improvement which included sending us updates so we could monitor the service.