Dimensions Somerset Sev Limited

Dimensions Somerset Ashbury

Inspection report

Ashbury
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Tel: 01823274677

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 5 and 6 June 2018 and was announced.

Dimensions Somerset, Ashbury 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.

Ashbury is registered to provide care and accommodation for up to eight people. The service specialises in the care of people who have learning disabilities and complex physical disabilities. The building is a single storey bungalow with a range of aids and adaptations in place to assist people who have mobility difficulties. All bedrooms are for single occupancy. The service is staffed 24 hours a day and all areas are accessible to wheelchair users. At the time of the inspection, seven people were living at Ashbury.

The people we met on the day of the inspection had complex physical and learning disabilities and not everyone could tell us about their experiences whilst living at Ashbury. We therefore used our observations of care and our discussions with staff, relatives, and visiting professionals to help form our judgements.

The service had a registered manager. The manager had been registered with CQC since April 2017. 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.

This is the first inspection of this service since it was transferred to Dimensions from the local authority in April 2017.

During this inspection, we identified that the provider needed to make improvements to ensure staff cared for people safely. For example, we identified concerns in relation to risk management. Staff had identified risks to people's health and safety in care plans but had not always completed a risk assessment and management plan. This meant new staff or agency staff would not know how to manage any identified risks for people.

There were improvements needed to some aspects of medicines recording. We identified the provider had not updated two, 'when required' medicines protocols, or recorded staff competency checks. We also found recording of covert medicine administration details were not completed. We have made a recommendation in relation medicines management including how the provider ensures all staff are familiar with the current national guidelines for managing medicines in care homes.

The provider did not carry out checks to make sure infection control was kept to a high standard. We found three of the communal toilets did not have hand washing signs, soaps, or hand towels for people to wash

their hands. This meant people were at risk of spreading infections. We raised this with the registered manager who immediately put up hand washing signs and arranged for hand washing products to be refreshed.

At the time of the inspection quality monitoring arrangements had not consistently identified shortfalls within the service. Internal governance systems were either not in place or had not been effective. The registered manager had a commitment to improving the care and support people received. However, they had not carried out internal audits or put an action plan in place with clear objectives to make sure they addressed the actions identified through the provider's quality and compliance checks. This meant the team found it difficult to know what was a priority. Following the inspection, the registered manager sent us further information that included service reports. These reports had identified actions required to develop the service.

We also identified areas of concern around confidentially and people being involved in their care planning; Care records were kept in places where visitors had access to them. Although, when we raised this with the registered manager they removed the care files and by the end of the inspection, peoples care records were moved to each person's room where people had access to them. We have made a recommendation in relation to the storage of records and care planning. Including demonstrating how the provider involves people and their relatives in all aspect of care and support.
Records showed that the provider did not involve people or their family members in any best interests meetings held. This meant staff could be providing care and support that would not be the persons preferred choice. Although, throughout the inspection we did observe staff asking people what they would like to do.

Although there were some concerns around how the provider managed risk in the service, we did observe people looking relaxed and happy. The provider had safeguarding systems in place, which staff knew about. Staff received training on how to recognise the various forms of abuse, which was regularly updated and refreshed.

We observed care staff addressing each person by name. Staff told us, "The most important people here are the people who live at the home." "We have to look after them as best as we can." Staff appeared kind and interacted with people well. Relatives told us they would be comfortable raising a concern or making a complaint if they needed to.

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 recorded in accordance with current national guidance.

Risk assessments were not always completed to enable people to receive care and support with minimum risk to themselves and others.

Infection control was not always carried out in line with current best practice and national guidance.

However, there was guidance in people's records on what action staff should take in the event they become unsettled or distressed, staff knew and understood this guidance.

The registered manager understood their responsibilities to raise concerns and record safety incidents.

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

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

Is the service caring?

Requires Improvement

The service was not always caring

The provider did not involve people, or their relatives when appropriate, in their care and support, as far as they were able.

However, people's privacy and dignity was not always respected.

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

Is the service responsive?

Good

The service was responsive

Staff were able to communicate with, and understand people.

People had opportunities to take part in some activities.

Is the service well-led?

Requires Improvement

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.

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Dimensions Somerset Ashbury

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 comprehensive inspection took place on 5 and 6 June 2018 and was announced. We gave the provider short notice because we needed to be sure the registered manager would be available for the inspection

One adult social care inspector, one medicine Inspector and one expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the Provider Information Record (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well, and the improvements they plan to make. We also looked at notifications sent in by the service. A notification is information about important events, which the service is required to tell us about by law.

During our inspection, we met with six people who used the service, the registered manager, one support lead; five support workers and two visiting professionals. The people who used the service were unable to communicate verbally and therefore we observed their interaction with staff and spoke with two family members who were closely involved in peoples care and support.

We also looked at records relevant to the management of the service. This included staff recruitment files, training records, medicine records, complaint and incident reports and performance monitoring reports.

Requires Improvement

Is the service safe?

Our findings

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

The provider had introduced new medicines recording systems. Where people had been prescribed medicines to be given 'when required', a system was in place to record guidance for staff to assess when it would be appropriate to give doses of these medicines. However, Staff had not followed this guidance as we found two people prescribed a sedative medicine before dental or chiropody appointments did not have individual protocols in place. This meant people were at risk of not having their medicines when they needed them.

There were records of mental capacity assessments, and the provider had carried out 'best interests' decisions for people receiving medicines covertly. For example, crushing medicines or mixing them with food or drink. Although staff told us that they consulted the pharmacy to check the best way give to people medicines covertly we found this information had not been recorded which meant agency or new staff would not know the safest way to give people these medicines.

The provider had introduced a new system to record practical competency checks to show that staff gave medicines safely. The provider had not completed these assessments for every staff member who gave out medicines at the time of our inspection. This meant the provider could not be assured that all staff giving people medicines were safe to do so. We reviewed three peoples Medicine Administration Record (MAR) charts which showed that staff had given people their medicines correctly in the way prescribed for them.

We people lived the issues we found around recording of people medicines with the registered manager who told us a new audit tool was being introduced to help monitor how people's medicine were managed. This should help to identify any areas for improvement.

People had reviews of their prescribed medication. The registered manager explained that staff were working in conjunction with doctors to support a prescribing initiative (STOMP) which aims to stop the over-medication of people with a learning disability, autism or who display challenging behaviours. This had led to an increase in the use of sensory measures to try to keep the use of sedative or anti-anxiety medicines to a minimum. For example, one person enjoyed using a sensory garden area.

We recommend that the provider ensures all staff are familiar with the current national guidelines for managing medicines in care homes.
Risk management was not robust. Staff had identified risks to people's health and safety in care plans but did not always complete a risk assessment that told staff how to manage the risk. For example, one person's care plan said they were at risk of choking due to eating too fast. Staff had not completed a risk assessment to manage this. One staff member told us, "We know how to work with them, we use two plates, we put small amounts of food on the second plate to support (person's name) to eat slowly." New staff coming into the service would not know this key information.

Another person would take food to the garden and eat the food from the floor. Staff had carried out a risk assessment in this case, which said staff should keep the patio doors locked at breakfast time. Staff had identified this was in the person's best interests and the least restrictive way of helping the person remain in the dining area to eat safely . However, staff had not involved the person in this meeting or taken account of how locking the patio doors may affect other people living in the service.

There was guidance in people's records on what action staff should take in the event they become unsettled or distressed. For example, one person did not like visitors. Staff told us, "Before any visitors come we have to prepare (person's name) to make sure they do not get anxious."

The provider's recruitment processes minimised the risk of employing unsuitable staff .The provider obtained references and completed a Disclosure and Barring Service (DBS) check. A DBS check ensures the provider can identify people barred from working with certain groups such as vulnerable adults.

Some areas of the service were in need of repair and restoration. Two bedrooms out of seven had en-suite bathrooms and bedrooms did not look personalised. One bathroom had a broken bath panel and the communal areas looked clinical rather than homely. We discussed this with the provider who told us they had identified this and recently been given a budget to update the décor. There was an action plan in place with details of which rooms were in line for redecoration and at the time of the inspection, we observed that the hallways had already been prepared for redecorating.

The risk of financial abuse was minimised. The provider had safe systems in place to ensure staff recorded and checked people's money. We looked at the financial records for three people. Staff had completed records accurately. Staff had supported people to budget their money safely. Appointees (either relatives or the Local Authority) managed people's income and arranged for each person to have sufficient money each week to pay for bills and living expenses.

The provider regularly serviced and maintained equipment. Overhead tracking was in place for people who needed a hoist to help them move. At the time of the inspection, no one required a hoist to help them move around although all staff had received training to ensure people were supported to use the equipment safely if they needed it. The service did have specialist baths and standing aids all of which had been serviced in 2018.

There were systems in place to safeguard and protect people when staff worked alone with them. There was a lone working policy and out of hours procedure, which staff knew about and staff said they could contact the provider at any time and they would respond. One staff member said, "We don't really work on our own, we go out with other staff but if we did go on our own we know what to do in an emergency."

Staff had access to policies and procedures on infection control that met current and relevant national guidance. The night staff carried out most of the cleaning duties such as cleaning the kitchen cupboards, ovens, bathrooms sluices. Although the service looked clean and staff knew what the expectations were, the provider did not carry out checks to make sure staff kept the cleaning to a high standard. This was evident when we viewed the toilets. We found three of the communal toilets did not have hand washing signs, soaps, or hand towels for people to wash their hands. We raised this with the registered manager who immediately put up hand washing signs and arranged for hand washing products to be refreshed. Staff did have access to personal protective equipment (PPE) to use when supporting people with their personal care.

Staff received food hygiene training and understood the importance of food safety, including hygiene, when

preparing or handling food. We saw records that showed staff were monitoring food temperatures. We did identify that one out of two fridges had not had temperature recordings completed since 2017 because there was no thermometer. We raised this with the registered manager who assured us they would purchase a thermometer and re start these checks immediately.

The registered manager produced a staff rota one month in advance this showed us the service was sufficiently staffed. However, staff told us the provider had reduced staffing levels since they took over the running of the service and planned to reduce the team even further. One staff member said, "We used to have seven staff on during the day which meant people had one to one support, now we have five staff members."

Staff told us the current reduction had had an impact on people living at Ashbury because occasionally people could not go out during the day due to staff shortages. We reviewed team meeting minutes in May 2018 these confirmed one person was not able to go out due to staff shortages. One relative also told us they had to come in every week to take their relative out to a club they enjoyed because staff could not always be available. We discussed this with the registered manager who told us the provider had set minimum staffing levels at five staff in the morning and four staff in the afternoon and that was what the rotas confirmed. Staff said, "People will always go out if they want to unless there is a shortage of staff due to sickness or emergencies on the day."

Although there were some concerns around how the provider managed risk in the service we did observe people looking relaxed and happy. People responded positively when staff spoke with them and relatives we spoke with said they felt people were safe living at Ashbury. One relative told us, "I feel (person's name) is very safe living at Ashbury, they always seemed happy, and although they enjoy coming home they are always happy about going back to Ashbury." Another relative said, "(Persons name) has been here a long time and is very happy here, the staff and the managers are great and I can't fault them at all. I am not worried about their safety and I feel confident that they are very safe."

Risks of abuse to people were minimised because the provider had safeguarding systems in place, which staff knew about. Staff received training on how to recognise the various forms of abuse, which was regularly updated and refreshed. There was an open and transparent culture. The provider encouraged staff to report any concerns. One staff member said, "We should be able to challenge." Another staff member said "people have regular seizures, if we noticed bruising that did not match the usual because of the seizure we would report it, we would know it wasn't normal."

The registered manager understood their responsibilities to raise concerns and record safety incidents, concerns and near misses and report these internally and externally as necessary. Staff understood how to recognise and report signs of abuse or mistreatment. Safeguarding and whistleblowing policies and procedures were available for staff to access.

Staff were clear about their responsibilities when incidents occur. The provider had policies and procedures in place to manage incidents and accidents. We spoke with staff who knew the reporting process and we reviewed incident records, which demonstrated the provider had investigated them appropriately.

The provider had identified some incidents and accidents as 'never events'. For example, if a person was injured as a result of something that was avoidable. If a 'never event' occurred it would be sent to a 'never event panel', made up of senior managers. The panel would agree any learning and recommend improvements to working practice. Staff told us the provider shared lessons learned following the conclusion of any investigation. We checked staff meeting minutes and incident reports, which confirmed

this.

Good

Is the service effective?

Our findings

People's needs were assessed and their needs and preferences recorded. The provider completed an assessment to check the service could meet the person's needs when they took over the running of the service . Assessments assisted staff to develop a care plan for the person and deliver care in line with the person's needs and wishes, current legislation, standards, and guidance.

People were supported by staff who had the appropriate skills, knowledge, and experience to deliver effective care and support. All staff completed an induction when they started to work for the provider. Records showed staff received comprehensive training, which enabled them to carry out their roles. All new staff completed the Care Certificate. The Care Certificate is an identified set of national standards that health and social care workers should follow when they are new to working in the care sector.

There was a system in place to remind staff when their training was due to be renewed. One staff member had not completed enough training and the registered manager had arranged to work a night shift with them so that they could support them to catch up on required training. Aside from the subjects the provider considered mandatory, such as safeguarding, moving, and handling, infection control, health, and safety, staff received training, which was relevant to the individual needs of the people they supported. For example, all staff had received training in managing epilepsy.

Staff planned meals with people. There were no set times for meals, each person had their own way of letting staff know when they wanted to eat. For example, staff told us, "(Persons Name) would take staff by the hand and pull them towards their food cupboard and (person's name) chose their food by pointing at objects and rejected food by pushing it away.

People had their own food cupboards and did their own food shopping with staff support. When someone wanted to eat staff would take two options from the persons cupboard and show it to the person so they could choose what they wanted. If they did not want any of those options people would look in their cupboards to see what else was available. Everyone ate at different times depending on when they were home from day trips or when they were hungry.

Staff assessed people's nutritional needs and recorded it in their care plans. Staff encouraged healthy food options and completed charts that reflected what food was served, and if people had any adverse reactions to specific foods, such as choking or coughing. However, staff did not
record times people ate or drank which meant staff had no way of knowing how long someone had gone without fluids or food. At the time of the inspection, one person had been asleep in the lounge most of the day. We had not observed this person have any food or fluids throughout the day and at 2.15pm we asked staff if this person was going to have any lunch. Staff told us they would eat when they woke up, but staff could not tell us when they had last eaten or drank anything. Following the inspection the provider sent the inspection team further information that included a fluid chart for this person.

The provider supported people to access services from a variety of healthcare professionals including GPs,

dentists, and district nurses. Care records demonstrated staff shared information with professionals and involved them appropriately. One health and social care professional told us, "They are kind here and always carry out any instructions we give for peoples physical health needs."

There were systems to ensure people's safety in an emergency 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 October 2017. 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. Records confirmed that staff tested alarms every week.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. People who lacked mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The authorisation procedure for this in care homes and hospitals is called the Deprivation of Liberty Safeguards (DoLS).

The provider made decisions in people's best interests. We reviewed three people's best interest records. Records showed that the provider involved care professionals in these meetings but did not involve the person or their family members. We discussed this with the manager who told us staff had worked with people for a long time, knew most of their personal preferences, and would always confirm with people that they were happy to carry out any form of activity. One relative told us, "I don't attend proper meetings about (person's name), but staff always let me know if there is a problem."

Requires Improvement

Is the service caring?

Our findings

During the inspection, we observed an open cupboard in the hallway with peoples care records on shelves. We also found care records in the dining area kept on an open shelf. This meant the provider had not respected people's privacy as anyone coming into the building could gain access to people's personal details. We raised this with the registered manager who immediately arranged for locks to be put on cupboards in both areas. We observed this happening and by the time we left the building all care records were secured.

We observed one person receiving foot care from a Chiropodist in the lounge in the afternoon. Staff told us the person was asleep and they did not want to disturb them. This meant staff may be delivering care without peoples consent. We raised this with the registered manager who assured us this was not normal practice and that staff know all personal care must be carried out in the person's room and with the persons consent and knowledge. Staff immediately stopped the activity and agreed to carry on when the person was awake.

Other care we observed was kind, compassionate and respected people's personal likes and dislikes. Some people were able to express their views verbally. Those that couldn't express their views verbally were observed smiling and looking relaxed when staff were with them. On arrival, we observed staff helping one person with their breakfast. Staff were kind and supported the person to drink their tea in the person's own time.

People who used the service were not able to tell us if they were involved in care planning. We reviewed three care records and whilst the provider had held best interests meetings, we found no evidence of how the provider involved people or their relatives in their care. However, relatives we spoke with said staff kept them up to date. One relative told us, "The staff are very good they let me know if there is a problem." The provider did not hold any resident or relative meetings to discuss the service delivery, which meant people and their relatives, did not have any input into the development of the service.

We recommend that improvements are made to some aspects of care planning. Including demonstrating how the provider involves people and their relatives in all aspect of care and support.

The staff were friendly, cheerful, and encouraging at all times. Staff chatted with people about the things they had done, places they had been, and things they had identified they wanted to do in the future. One person sat with staff planning a holiday, staff consistently talked to the person about the things they liked to do and the person responded with lots of smiles. Relatives we spoke with told us, "I'm very happy with the staff and the managers I feel (person's name) is very happy living here and they do what they can to make them happy." Another relative told us, "Staff are very accessible, always someone to talk to."

Staff listened to people and respected their choices. We observed staff asking people what they wanted to do and giving them choices. For example, staff asked one person if they wanted to go out for a walk, they asked where they would like to go and the person wanted to go to the café, so staff went with them to their

favourite café." A relative told us, "The staff do treat (person's name) well. They are always smiling and friendly. (Person's name) is helped to make decisions about the things that they like to do."

Staff spent time chatting, encouraging, laughing, and joking with people. Everyone we observed was smiling when staff approached them. Staff held people's hands gently when talking to them to get their attention One relative told us, "When my daughter had a fall and had to go to A&E, both managers were there with her and seeing to her wound, they are both very good."

The registered manager and staff knew how to assist people to access advocacy services, if this was needed. An advocate is a person who works with people or a group of people who may need support and encouragement to exercise their rights.

Staff sought ways to communicate with people. Care records had communication profiles that demonstrated how staff should support people to communicate. People used simple communication signs, for example, through use of facial expressions, pictures, and hand gestures to communicate how they were feeling. Regular reviews took place with the person and people who knew them best such as family, key worker and social worker. Reviews reflected on their achievements, goals and aspirations, and where changes were identified these were reflected in the person's care plans.

Relatives could visit people at any time of day. There were no restrictions on visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection, several visitors came to the service to see people. It was clear that staff knew the visitors well when we heard them speaking with them. Relatives we spoke with were very positive about the way staff treated them and felt comfortable visiting at any time of the day.

Good

Is the service responsive?

Our findings

The provider was responsive to people's needs. The support plans were clearly set out and easy to read. They provided a range of information about the person that included their preferred daily routines, likes, and dislikes and details of people and things that were important to them. Care plans we reviewed gave details of what the person liked to do and how staff could support them to do their favourite activity. This was important for staff to understand because some people receiving support had limited verbal communication. However, the provider did not review care plans regularly which meant staff may not have access to the most up to date information on how to meets people's needs.

The provider carried out person-centred activities and encouraged people to maintain their hobbies and interests. Staff described each person's individual favourite things they like to do. For example, staff told us they had identified an activity centre where one person could fulfil their dream of being a cowboy for the day. We observed staff discussing this with the person whose eyes lit up when talking about the adventure staff were arranging for them. One person enjoyed swimming. Staff arranged for this person to attend the swimming baths near to their relatives so that they could join them each week. One relative told us "There is not always enough staff and that's where I come in, I visit (person's name) twice a week and I take them to the resource centre." They said, "I need to do this as (person's name) needs one to one. The relative added, "I am very worried about how things are going to change and how this will affect (person's name) quality of life.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. All those currently receiving support at the service had a learning disability and varying communication abilities.

Staff were able to communicate with, and understand each person's request and changing mood as they were aware of people's known communication preferences. Care records contained communication plans. This included information about hand signals; gestures and key words people used to express them self. We observed staff communicating well with people by listening and confirming what people had requested.

Staff also told us they had identified that one person would benefit from a Grid Pad to help them communicate better. A grid pad is a tablet with specific software that has symbols the person can press, that tells people what they want. Staff had fundraised for this piece of equipment, which meant they could purchase the Grid Pad for the person. Staff told us this had made a big difference to the person's ability to communicate with people and staff.

The service did not have any signs directing people to specific places. For example, bathrooms and the registered manager's office were not easy to identify and there were no staff identification boards for people to see who was who within the service. We also observed people's rooms were not identified which meant people could enter someone else's room by accident. However, following the inspection, the registered

manager advised us that bedroom doors were painted different colours so that people could identify their own rooms. They told us the staff worked with people to choose an individual colour for them, which meant they are individualised and recognisable.

People who used the service were unable to make verbal complaints. There was a complaints procedure displayed in the hallway of the service this was not in easy read format so people using the service may not understand the procedure and the provider did not produce service leaflets for people explaining how they could make a complaint. Relatives told us they had not received any formal complaints information.

The provider had not received any complaints in the last year. Staff told us they would know if people were not happy. Staff said people's body language showed when they were upset or unhappy. For example, during the inspection, the registered manager had locks put on the cupboards to ensure care records were secured. However, this had an impact on one person who became very agitated at having the door locked; they were used to seeing it open. The provider acknowledged this immediately. The care records were removed which meant the cupboard could remain unlocked.

The provider removed the care plans and placed in people rooms, which also meant people had access to their records. Relatives we spoke with told us, "The manager was very good and always had an open door and made themselves available to talk to people and listen to their concerns." Another relative said "The manager is easy to talk to, I could discuss any worries I might have."

At the time of the inspection, no one was receiving end of life care. Staff were aware to liaise with the person's GP and the district nurse team in the event someone did require end of life care. One person had a funeral plan in place, which staff knew about.

Requires Improvement

Is the service well-led?

Our findings

Leadership was not robust. Current governance arrangements had not consistently identified shortfalls within the service. We reviewed how staff identified and managed risks to people's health, safety, and welfare. We found that whilst provider level audits were completed, internal audit systems had failed to identify the shortfalls we identified from this inspection. Following the inspection, the registered manager sent us further information that included service reports. These reports had identified actions required to develop the service.

Examples of failings within the governance arrangements identified by the inspection team included areas of medicines management that were unsafe and the absence of risk assessments within care plans that did not ensure people living within the service fully protected from the associated risks. In addition to this, we found that effective monitoring and management of the service had not identified basic levels of provisions such as paper towels and soap to reduce the risk of cross infection were available for people, visitors and staff. This increased the risk of cross infection. The absence of oversight in relation to care planning and recording content had not identified people, or others acting on their behalf, had been involved or consulted in care planning.

In relation to provider visits, we saw records that showed regular visits to the service were undertaken. The records we reviewed showed that the quality and compliance team had identified actions to improve the environment. However, additional internal governance systems were either not in place or had not been effective. For example, staff had identified risks to people health and safety but had not completed risk assessments for every risk they had identified, which meant the provider could be compromising people's safety. The provider had not identified this within their quality and compliance checks.

The registered manager told us the provider had carried out an annual quality assurance survey in order to seek the views and opinions of people or their representatives. We could not review any results of the survey at the time of the inspection because the provider sent the survey questionnaire out in April 2018 and the results had not been collated at the time of the inspection. We asked staff if they had taken part in any satisfaction surveys to help improve service development. One staff member said, "I don't think I have." Another staff member said, "No we don't get anything like that." Following the inspection, he provider sent in further information that identified how staff had been involved in service development. This included information on the staff intranet and emails that had been sent to staff for their feedback.

Staff did not have a clear understanding of the key values and focus of the service. Although they were committed to continuously improving the service, they did not know what plans the provider had. The provider did not display the organisation's core values for people to see.

People had lived at Ashbury prior to the service transferring to Dimensions and some staff had worked there for a long time. This meant staff had a good understanding of people's care and support needs. A relative told us, "They know what (person's name) likes." However, staff told us the provider was establishing a new structure, which might affect the current service. Staff told us they did not know what the proposal was or

how it might affect people who currently lived at Ashbury. Staff said, "We are worried about how this will affect everyone as well because some staff will be made redundant and it will have a knock-on effect." However, following the inspection the registered manager sent in further information that included the consultation paperwork with the proposed staffing restructure. They also sent out question and answer emails weekly to give staff the opportunity to ask questions about the changes and staff meeting minutes demonstrated the changes were discussed with staff at every opportunity.

We discussed these changes with people relatives, one relative told us, "I am worried about the future of the service and whether people needs will continue to be met effectively." Another relative said, "The company have not communicated with us, which has left us feeling worried and upset about the changes happening." Staff told us, they discussed people's needs at team meetings so everyone knows how to support people but they do not know what to say to relatives about the changes to put their mind at ease. A third told us, "(Persons name) has always been very happy here." Adding, "After all this time of them being settled and happy we didn't think that we would have to worry about things like this at my age. I have not heard anything from Discovery, the new company at all." Following the inspection, the registered manager sent in further information that included a letter which was sent to people's relatives in May 2018 explaining the changes that were proposed.

There was a registered manager at the service. 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.

A support lead supported the registered manager. The registered manager was positive about the support they received from the operations director and they had access to other specialist professionals such as human resources and a quality lead.

Staff told us morale was low at times because of all the changes that had taken place. The provider had told staff there would be redundancies and reductions in salaries. Staff did not know who would be affected and told us they were in a consultation period. One staff member said, "I love my job, best job ever. I am worried about the changeover because of how its effecting structures and that makes us worry about how that will impact on the people." "The Registered manager told us more changes were still to come.

Although it was a difficult time for staff, there was a culture of support and cohesiveness amongst staff. Staff told us they felt supported in their roles by colleagues and the registered manager. All staff we spoke with told us that they could raise issues without fear of bullying or intimidation and we found no reported incidents of bullying within the team.

Staff had an annual appraisal where they were able to discuss their performance and highlight any training needs. There were records of individual formal supervision with a manager. Supervision is a process where members of staff meet with a supervisor to discuss their performance, any goals for the future and training and development needs. Staff had opportunities to develop their skills. One staff member had completed other training on line such as Dementia in order to support some of the people at Ashbury who had been assessed as having Dementia.

The registered manager held regular meetings with staff. Areas discussed included, safeguarding people, use of mobile phones and expectations of CQC.

The provider worked collaboratively with organisations to support care provision, service development, and

joined-up care. For example, GPs and district nurses visited people at the home to see people who had physical healthcare needs or required additional support. This helped to make sure people received care and support in accordance with best practice guidance.
One professional we spoke with said, "I haven't worked with the team a lot but they always seem to do what's best for the person." Another professional visiting the service said, "I've been coming here for years and the staff are always very supportive, adding they are polite and professional."

The provider had ensured they had notified CQC of significant events in line with current legislation. This meant external agencies were able to monitor the care and safety of people using the service.