Dimensions (UK) Limited

Dimensions 53 Cambridge Road

Inspection report

53 Cambridge Road
Southampton
Hampshire
SO14 6UT

Tel: 02380554855
Website: www.dimensions-uk.org

Date of inspection visit:
26 September 2018
27 September 2018

Date of publication:
07 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We undertook an inspection of the service on 26 and 27 September 2018. The inspection was unannounced. At our last inspection we rated the service good.

Dimensions 53 Cambridge Road is a care home for up to six people with a learning disability. The building was purpose built, has six bedrooms across two floors, a shared living room and a kitchen dining area. There were five people living in the home at the time of the inspection.
The care service has been developed and designed to meet the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion to help ensure people with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Since our last inspection, there had been a change of management at the service. The previous manager had left and a new manager had been appointed. The new manager had submitted an application to CQC to register as manager for the service. At the time of inspection, this application was still in progress. 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.'

At this inspection we rated the service 'requires improvement'. We found that the service was in breach of four regulations. You can see what action we told the provider to take at the back of the full version of the report.

People's risks were not fully assessed and managed in the least restrictive way. One person was put at risk of serious harm from the inappropriate use of bed rails. Medicines were not stored securely and people did not always have guidance for the use of their medication.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. People's capacity to make decisions was not always assessed when decisions were made on people's behalf. The provider had not always applied the principles of the Mental Capacity Act, resulting in people being deprived of their liberty.

Records were not kept accurately and were not always up to date. We found that the provider did not have sufficient quality assurance processes in place to identify quality and safety issues and take action to rectify these.

People were protected from the risk of abuse or neglect by staff who knew what signs to look for and how to report issues. Staff openly reported incidents and the service took action to prevent re-occurrence.

There were sufficient staff during the day to meet people's needs and enable people to take part in social

activities as they wished. However, staff reported there was not sufficient staffing levels at night to safely support people.

Staff had access to training, and had the appropriate skills, knowledge and experience to support people. The service referred people to other professionals as required and enabled people to access health services, such as their GP and dentist.

The premises were adapted to meet people's needs and preferences. People had a choice of food to meet their dietary needs and preferences.

Staff used different methods of communication to meet people's needs and ensure they were able to express their views and be involved in conversation.

Staff respected people's dignity and privacy. Staff valued people's individuality and enjoyed working in the home.

Staff ensured people had access to social activities which they enjoyed. People were encouraged to maintain relationships with people who were important to them.

Further information is in the detailed findings below.

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.

People's risks were not fully assessed and managed in the least restrictive way.

Medicines were not stored safely and securely.

People were protected from neglect and abuse. Staff reported incidents and the service took action to reduce the risk of re-occurrence.

Is the service effective?

Requires Improvement

The service was not always effective.

People's capacity to make significant decisions was not always assessed. People were not always supported in the least restrictive way.

Staff had the appropriate skills, knowledge and experience to meet people's needs.

People were supported to have access to food and drink to meet their individual needs and preferences.

The premises were adapted to meet people's needs and people chose how their rooms were decorated.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect. People's privacy was respected. Staff spoke passionately about their work with people.

Staff knew people well and adapted their communication methods to engage people.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities that interested them.

Staff encouraged people to maintain relationships with people who were important to them. The service was proud of the relationships they had with families.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had undergone a recent change in manager.

Not all required incidents had been reported to the CQC. People's records were not up to date or accurate.

The provider did not have robust quality assurance processes in place.

Staff and people's relatives had confidence in the manager to make the improvements required.

Dimensions 53 Cambridge Road

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 27 September 2018 and was unannounced.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that helps gather information about the service and helps to inform the inspection. We reviewed information we held about the home including previous inspection reports and statutory notifications. A notification is information about an important event which the service is required to send us by law. We also reviewed information contained within the provider's website.

The inspection was carried out by one inspector. During the inspection we observed people's interactions with staff, and a mealtime. We spoke with five members of staff, two people living at the service and one member of a person's family.

We reviewed records related to two people including their plans of care and risk assessments. We reviewed other records including; two medication administration records, team meeting minutes, policies and procedures, activity plans and meal plans. We reviewed the provider's quality assurance documents and action plans of improvement.

Requires Improvement

Is the service safe?

Our findings

People were smiling, they were comfortable with staff and spoke openly with them. One person's relative told us they felt the home was safe and told us, "Oh yes, I think he is safe here." Staff we spoke with had a good understanding of types and signs of abuse. Staff knew people well and understood that changes in behaviour could be an indication of abuse. Staff told us they felt confident to report any issues, that these would be taken seriously and acted upon.

One person's risks were not managed in the least restrictive way. This person was at high risk of falling and had previously fallen from their bed resulting in a serious injury. Following this, healthcare professionals advised staff to provide a specialised bed which could be lowered close to the floor to reduce the risk of injury if the person fell out of bed. Staff were also advised to undertake 30 minute checks during the night, to check the person had not fallen, and not to use bed rails as this would restrict the person's liberty. A care plan for the specialised bed was recorded in the person's care and support document. the manager and a care worker told us they used bed rails at night with this person. The use of bed rails was not included in their care plan, there was no risk assessment for their use. There was no recording the person's capacity to consent or that the decision was made in the person's best interest. Use of bed rails for someone with confusion can pose a higher risk to their safety as the person can climb over the bed rails or become trapped in them and sustain a serious injury.

The person's care plan had recorded that they required checks by staff every 30 minutes in the night, which was in line with guidance from the physiotherapist. However, this had been crossed out. The care plan stated the person no longer required 30 minute checks. There was no reason recorded for this change and this was not in line with professional guidance.

This was brought to the manager's attention. Following the inspection, the manager advised that bed rails were no longer in used and they were exploring the use of a crash matt in conjunction with the lowered bed at night. They advised they had reinstated 30 minute checks. They also advised they had implemented a risk assessment based on national guidance for any future consideration of the use of bed rails.

People's risks had not always been assessed, resulting in one person being at risk of significant harm. Risks were not managed in the least restrictive way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
One person was at risk of choking, they were on a modified diet to reduce the risk of choking and staff were aware of this risk. They had an appropriate care plan in place and we observed this followed safely in practice.

Medicines were not stored securely. Medicines were stored in a locked cabinet in the manager's office with a second locked box inside for "controlled drugs", which are drugs that are more potent and have legal requirements for their administration, storage and destruction. The key for the medicines cabinet was hung on the wall, the key for the controlled drug locker was inside the medicines cabinet. As this was not a secure arrangement this posed a risk that people or unauthorised staff could access controlled drugs. Staff stated

the door to the office was locked when no one was there.

One person's care plan had not been updated to reflect that they had daily medicines. The person's care plan stated, "I do not have any regular medication, it is all PRN [as required]." One person had medicated skin cream which was to be used 'as required'. There was no protocol for its use or body map to show where the cream was applied. This could result in staff not applying the cream correctly in line with its prescribed purpose and result in the person's skin becoming sore. Records showed that people had received their regular medicines as prescribed.

Protocols were in place for use of 'as required' pain relief which gave information about when the medicine should be taken, maximum doses and when to seek medical guidance. The service recorded the date and reason the medicine was taken so that trends could be identified to trigger seeking medical advice if needed. However, the reason for the last administration of pain relief administered for one person had not been recorded. Stock check audits had not been completed correctly and had differing numbers in the same record.

Medicines were not stored securely. Stock control procedures were not robust and there was no guidance for staff on the use of a medicated cream. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they did not feel there were enough staff at night. Staff told us there were three people in the home who were often awake at night and could become anxious, express behaviours which challenged or could wander around the building. The service had three staff members on duty in the day and one staff member at night. The manager had implemented a diary to record people's activities and behaviours and risks at night as a means of identifying additional staff numbers needed. They told us this would help them to seek further funding for additional night time staff if required.

During the inspection there were enough staff to provide support that people needed during the day. People could go out with staff support when they wanted to. Staff and a person's relative told us they felt there were enough staff in the day time.

The service had two staff vacancies at the time of the inspection and were actively recruiting. The service used agency and bank staff to ensure there were enough staff on duty based on people's needs. The service used consistent bank and agency staff who knew people well to ensure continuity of care for people.

The provider undertook regular health and safety checks of the building. The health and safety audit from August 2018 had identified that some of the fire doors were not closing when the alarm was being tested. This had been escalated to the building owner and to the fire service who undertook a review on 27 September 2018 - during this inspection. Following the inspection the Fire Service issued an Enforcement Notice to undertake works to make the building safe.

The service undertook fire drills every six months to ensure people were able to leave the property safely in an emergency. One person declined to leave during a fire drill, this was reflected in their personal emergency evacuation plan. This had been discussed with them and a clear set of actions was added to their evacuation plan for staff and the Fire Service. One person's evacuation plan had been updated in their record, however an old version was present in the fire folder; this was resolved during the inspection.

People were protected from the risk of infection. The home was clean and tidy, hand washing facilities were available to staff and people. There was personal protective equipment available, such as gloves, which was

worn by staff when needed.

Staff reported issues and incidents promptly and these were acted upon. The provider recorded incidents on their reporting system and there was evidence of actions taken to reduce the likelihood of re-occurrence. Staff told us that they received feedback about incidents which affected them or the way they supported people.

The provider used robust recruitment processes to check staff were suitable to work in a cares setting. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. Records showed that checks had been made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and to prevent unsuitable staff from working with people made vulnerable by their circumstances.

Requires Improvement

Is the service effective?

Our findings

We reviewed how the service applied The Mental Capacity Act 2005 (MCA). The 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff we spoke with understood the principles of the MCA. Staff we spoke with told us that people had the capacity to make day-to-day decisions, but that they may not have capacity for more complex decisions. One member of staff gave an example of when someone needed a hospital procedure, the hospital undertook a best interest meeting.

Records showed that the principles of the MCA were not always applied appropriately in practice. One person had bed rails used at night which restricted their free movement. This was not documented, their capacity to make this decision had not been assessed and there was no evidence of a decision made in the person's best interest.

Another person's relative told us the person did not routinely have access to drinks in their room, staff told us this was to encourage them to leave their room to eat and drink. The person was at risk of choking on foods but not fluids. The person's capacity to consent to these decisions had not been specifically assessed and there was no evidence of a decision being made in their best interest.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that all five people in the home were subject to DoLS.

When discussed with the manager, they did not feel that three of the five people would meet the criteria; that being that they lacked capacity to decide where to live, and that they were under constant supervision. DoLs Authorisations for people had expired and a renewal application had not been submitted, for example one person's DoLS authorisation was dated May 2016 with a 12 month timeframe. Staff did not know who was subject to a DoLS.

The provider had not always applied the principles of the Mental Capacity Act in assessing people's capacity to make decisions, resulting in people's right to make choices about their lives being restricted. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had access to training and development which enabled them to have the knowledge and skills to care for people. One person in the home was living with dementia. Staff had undertaken dementia training and the manager was sourcing further training to support staff to meet the person's changing needs.

Staff fed back positively about the support they received when starting their jobs. One staff member told us, "[The staff] are so nice and explain everything." They told us they had "very good support" when they started. Staff completed an induction programme which included the Care Certificate. The Care Certificate includes the social care standard training which care workers need to meet before they can safely work unsupervised.

Staff had supervision and completed competencies related to specific skills to enable them to provide individualised support to people. Staff had annual appraisals to review their performance and development. Some staff undertook lead roles in certain areas, such as fire or medicines management, and supported other staff in this area.

People were supported to have a healthy dietary intake. People's needs and preferences were respected in their meal choices. The mealtimes were relaxed and social events. People sat together in the dining area and chatted with each other and staff. People were not rushed and had the support they needed. People's independence was promoted through encouraging them to get drinks and to tidy up after they had finished their meals.

People were supported to take part in cooking if they were able to. During our inspection one person was encouraged to help make an omelette with staff. The person was very happy with their meal and told us it was "very nice" and made appreciative noises.

People had access to healthcare services, such as the GP, opticians and dentists. Professional support and advice was appropriately sought, for example one person had been referred to a speech and language therapist due to their nutrition and swallowing difficulties.

The premises were adapted to meet people's needs and preferences. One person had moved downstairs as their risk of falling had increased. People chose how they wanted their rooms decorated and what decoration they wished to see in communal areas. There was sufficient space in the home for people to socialise and to have privacy when they wanted.

The manager had allocated funds to renovate the garden space. People had chosen what they wanted in the garden and plans had been made based on people's wishes. One person was growing tomatoes and wanted some space to do this, another person requested a raised bed to grow potatoes and other vegetables.

Good

Is the service caring?

Our findings

People were cared for by staff who knew them well. Staff spoke with people as equals. Staff showed an interest in people and spoke with them about things that mattered to them, such as their favourite television programme or their friends and families.

Staff knew how to communicate with people based on their individual needs, for example they communicated with one person using Makaton. Makaton is a language using signs and symbols along with speech to help people communicate. Staff used language and ways of communicating which engaged people in conversation.

Staff spoke respectfully of people and valued their right to confidentiality. Staff were respectful of people's personal space and they had privacy when they wanted. Staff knocked on people's doors before entering their rooms and asked people what support they wanted. Staff encouraged people to be as independent as possible and saw people's potential.

Staff recognised people's emotional needs and were caring in their approach to meeting them. For example, one person became upset while eating lunch. Staff recognised this quickly and sat with the person, comforting them, understanding what made them upset and helping them make plans they could look forward to.

People were involved in making day-to-day decisions about what they wanted to do, eat or wear. People's families were involved in their lives and the manager told us they were proud of the relationship they had with people's families. People were supported to maintain relationships with those who were important to them.

One person's relative told us that some staff "don't care", but there are some that are "amazing". They spoke very highly of two care workers and of the manager. They felt that some staff needed to alter their approach, to be less "loud" and more "gentle" in their tone. They told us that their loved one sometimes had other people's clothes on as these are not washed separately and felt staff did not always take care to look after his clothes. This was brought to the attention of the manager who gave assurances this would be improved.

Staff spoke passionately about their work, with one describing it as their "second home". One member of staff said, "I love it…I love working with [people]." Another member of staff told us, "I love coming to work."

Good

Is the service responsive?

Our findings

People were able to take part in activities and social events that they wanted to. Staff supported people to find out what they liked to do and people could choose what they wanted to do each day.

Staff respected that some people were very sociable and enjoyed activities out of the house, and some preferred to stay at home. Staff worked flexibly and stayed late to allow people to take part in activities out of the home. People went to day services locally.

During the inspection, people told us about the activities they were doing and said how much they enjoyed them. One person had been out shopping with staff and told us they had a "nice time". They expressed their excitement when staff told them they had arranged for them to attend a local disco arranged by another resident's day centre. Staff helped them plan what they wanted to wear, they said, "I'm going to get dressed up!"

People were supported to plan and go on longer trips and holidays. Staff were working with a family member to organise a holiday for one person.

Some people in the home lived with sensory loss. Staff adapted the way they communicated to enable people to have choice and participate in activities. Information about people's physical abilities and communication needs was captured in care plans and in hospital and dental passports to easily communicate this information with other services.

The provider had created easy read versions of the complaints policy to support people to know how to make a complaint. This was available in their care record. The manager respected people's views and opinions and took complaints and concerns seriously.

One person had made a complaint to the manager about another person living in the home who had been shouting and swearing at them. The manager explained that they had discussed the complaint with both people involved and the person's behaviours had reduced since.

One person's relative told us they felt involved in their care, they visited frequently. They told us the service "keeps in touch" and she was kept updated.

There were no end of life care plans in people's care records. The manager told us the service was developing plans with families for people in advance of them approaching the end of their life. One person had been supported to purchase a funeral plan. This was an area the manager wanted to develop and improve. No-one in the home was approaching the end of their life, however most people living in the home were in an older age group and one was living with dementia.

We recommend that the home implement best practice guidance for people growing older with learning disabilities to work with families to develop plans for the future, including the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection, there had been a change in manager. The service had a recently appointed manager in place who had applied to become registered. The manager had previously been responsible for three services for the provider, and had recently started managing only 53 Cambridge Road in order to focus on quality improvement.

During this inspection we identified a significant incident which would be reportable to the CQC as a statutory notification. Failure to report this incident is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People's records were not up to date or reviewed regularly. The manager stated records were reviewed and updated every six months, the records we looked at had the last review documented in January 2018. There was evidence that records had been updated and amended when people's needs changed, however changes were not clearly dated and out of date information was not removed.

People's records were not accurate and contained conflicting information. For example, one person's record stated in one section "I bath independently", in another section stated "I require no support when having my bath" and then later stated "I need support to wash my body properly [due to their physical abilities]". This put people at risk of harm when new or agency staff were working, or in an urgent situation where information was required for emergency services.

The provider had a system of quality assurance and audit in place, however this was not sufficient to identify quality issues requiring action. Though some areas for improvement had been identified and acted upon, these audits had not identified a number of quality and safety issues outlined in this report.

The failure to implement effective systems to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had identified priority areas for improvement, some of which reflected the findings of this inspection. The manager identified improvements to records as a high priority, with plans to implement an electronic records system in the near future.

The manager told us that formal management supervision and team meetings had not been taking place regularly, the last minutes recorded were from November 2017. The manager told us that staff were due to have appraisals and these had been booked in with staff. The manager had asked for feedback from people and relatives to utilise in performance evaluations for staff.

The manager had a clear set of values for the home which were reflected in the approach of the staff working there. One member of staff told us their priority was to support people to "have a happy life" and "to be independent". The manager understood their role and responsibility and had the appropriate skills and

knowledge to manage the service.

People spoke highly of the manager. One staff member said, "[Manager] is very good. She is always on the end of the phone." Another member of staff said, "[Manager] is wonderful." They said they had very good support when they started working for the service.

The service worked with other agencies to ensure they shared relevant information about people, such as GPs, learning disabilities services and hospitals where needed. People's information was treated confidentially.

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 The provider failed to notify us of an incident meeting the criteria for notification. Failing to notify the CQC prevented us from undertaking our regulatory duties.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not always act in line with the Mental Capacity Act 2005 in relation to making decisions in people's best interests when they were unable to consent to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not did put measures in place to assess monitor and mitigate risks to people. The provider did not have effective systems in place to ensure the safe management of people's medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. Records were not accurate or up to date.