Dimensions (UK) Limited

Dimensions 123 Calmore Road

Inspection report

123 Calmore Road
Calmore
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19 March 2019

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service: Dimensions 123 Calmore Road is a residential care home providing personal care to three people who had a learning disability or autistic spectrum disorder at the time of the inspection.

People's experience of using this service:
• Staff received safeguarding training and regular updates and would not hesitate to whistle blow if their concerns were not listened to.
• Risks were assessed in areas such as environment, care and behaviours and actions were taken to mitigate any identified concerns.
• Staff were safely recruited and participated in an in-depth induction and mandatory training before commencing working with people.
• Sufficient staff were deployed to support people in the service however some staff needed additional guidance in how to support and occupy people.
• Staff turnover was high and more staff, who had significant knowledge and experience of the people they cared for, would be leaving in the weeks following our inspection. Recruitment was underway to fill vacancies.
• Medicines were safely managed however the medicines cabinet had patches of chipped paint inside which exposed bare metal which was an infection control risk. The provider was planning to replace the cabinet.
• The premises were clean and an infection control audit annually ensured that safe hygiene levels were achieved and maintained.
• Staff supervisions had been regular however were now all slightly overdue. The locality manager had plans to address this. • People were supported with nutrition; a photographic menu was in use and staff knew how to best support people to eat at mealtimes.
• Peoples rooms were personalised and in one bungalow, people also had a living room which had been personalised with their belongings, art work and photographs.
• People were supported to access GP's and other medical professionals as required.
• Deprivation of Liberties Safeguarding authorisations were applied for and though one person's authorisation had expired, a new application had been submitted and the provider was awaiting a response.
• Staff were caring and respectful most of the time. We saw one staff member who was less respectful which we discussed with the locality manager.
• Staff could interpret people's communication well, they understood when words were used that had a different meaning for people and could understand what non-verbal sounds meant.
• There was an activity plan each day however this was minimal. The provider told us they were reviewing the provision of activities and would be introducing a fuller in-house activity provision.
• Several changes to the management team of the service had unsettled staff members who had felt unsupported as indicated by high staff turnover and high staff sickness levels. A new management team had been put in place a week before our inspection and, though staff morale was not high, it had improved already.
• Monthly staff meetings had not taken place as planned in 2018, only two had been recorded.

The service met the characteristics of Good in most areas. More information is in the full report. Rating at last inspection: Good. Report published 29 September 2016.

Why we inspected: This was a scheduled and planned inspection based on the previous rating.

Follow up: We will continue to monitor the service and will re-inspect according to our re-inspection schedule for services rated as Good.

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

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 safe Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Dimensions 123 Calmore Road

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection team consisted of one inspector and one inspection manager.

Service and service type:
123 Calmore Road is a care home. People living in care homes receive accommodation and nursing or personal care. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The provider had applied to add the service to an existing registered managers portfolio. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced. Inspection site visit activity started on 18 March 2019 and ended on 19 March 2019.

What we did:
Before we inspected 123 Calmore Road, we reviewed the information we already held about the service. We looked at notifications. Notifications are sent to us by the service to tell us about significant events.
We reviewed the Provider Information Return. The provider completes this at least once every year to tell us

what the service is doing well and about any plans to improve.
During our inspection we spoke with four support workers, two locality managers, an interim operations manager and one relative of a person living in the home.
We reviewed records maintained by the service including records of accidents, incidents and complaints, audits and quality assurance reports, health and safety monitoring, two peoples care records and one staff recruitment file.
We sought feedback from two health and social care professionals and received one response from those approached.

Good

Is the service safe?

Our findings

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

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• Staff were trained in safeguarding and received annual updates to their training. Staff understood the process of whistleblowing and would not hesitate to approach outside agencies if they had concerns that had not been addressed internally.
• People appeared to be safely cared for. Staff knew people well and ensured that their needs were met in a way that made them feel safe and comfortable.

Assessing risk, safety monitoring and management
• Regular contractor checks were completed on the fire alarm system however inhouse weekly checks such as emergency lighting checks and fire bell checks had not been completed while the staff member responsible was absent for several weeks. Prior to their absence, checks had been completed as scheduled. The locality manager told us they would look at ways to ensure this didn't happen again.
• People had personal emergency evacuation plans, (PEEP's). These were available in a grab file next to one of the fire exits. The grab file contained contact details for local hotels that could provide overnight accommodation in the event of evacuation, contacts for people's relatives and a list of contacts for managers within the provider organisation. The list of provider contacts in the grab file was not current. This was updated as soon as we made the provider aware of this. A key to the services vehicle was also stored in the grab file which ensured that the car could be moved to safety, away from the building, and be used to transport people to safety.
• Peoples risks were assessed to ensure that risks associated with health, behaviours, the environment and mobility for example were mitigated.

Staffing and recruitment
• The provider had a robust recruitment procedure and staff were not able to commence in post until all pre-employment checks had been completed.
• Recruitment files contained two references, a full employment history, evidence of qualifications, interview notes and a completed application form. A Disclosure and Barring Services (DBS) check was also completed before the person began working for the provider. The DBS check enables employers to make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.
• We saw sufficient staff deployed to support people in the service. There were two adjoining bungalows on site and staff were deployed to work in either service. At times, staff needed to be relieved of their duties for debriefing if there was an incident of challenging behaviour. Due to some staff being unable to cover one of the bungalows due to health reasons or having not been SCIP trained, this was not always achieved and staff would have to continue working without time to gather themselves following an incident.
• Staff turnover was high and more staff were leaving in the weeks following our inspection. There had been no permanent, effective, long-term management within the service for some months. The recent

management changes had provided much-needed support to staff members and there were additional staff being drafted in to work from other locations within the providers services to support the service. Newly interviewed job candidates were undergoing pre-employment checks and would to commence in post once cleared.

Using medicines safely
• Medicines were safely managed. We checked medicines in one of the two bungalows and saw that medicine administration records (MAR's) were correctly completed without any missed signatures and amounts of medicines in the cabinet were consistent with medicine audits.
• We saw that one homely medicine provided by a parent had passed its expiration date, this was immediately disposed of by the provider and had not been used. We also saw that one person had a stock of over 300 paracetamol tablets. These were given on a PRN, or as required, basis and most weeks no more than one dose of two tablets per day. We recommended reducing the stock level significantly to reduce the risk of tablets passing their expiration date before being used and to reduce the risk of potential harm if a vulnerable person accessed the medicines cabinet. The locality manager told us they would dispose of the older tablets and not reorder until stock levels were at a more reasonable level.
• The temperature inside the medicines cabinet was recorded daily. We saw records that showed that the cabinet had been at safe temperatures over recent weeks however when asked, staff told us it was difficult to maintain a safe temperature during warmer weather. Medicine storage should not be located in areas such as kitchens which may become hot or steamy as this can cause deterioration to medicines.

Preventing and controlling infection
• The service was very clean and there were no unpleasant odours. Decoration was in good order and washable flooring was throughout the building.
• The medicines cabinet was in poor condition, though secure, some of the coating had worn away and there were bare metal areas which may harbour bacteria. We spoke to the locality manager who was already researching replacing the one central medicines cabinet with new, individual cabinets for people's rooms.
• An annual infection control audit ensured that hygiene standards were maintained.

Learning lessons when things go wrong
• Accidents and incidents were logged and reviewed by managers within the providers organisation. Themes and causes were looked for and actions taken to minimise future concerns.
• Staff learned how best to support people as they managed incidents involving them. A newer resident needed significant support to manage behaviours, staff were becoming more familiar with possible triggers to the person and were becoming more able to divert the person and minimise incidents. This was a slow process however each incident highlighted effective ways to work with the individual.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before they moved to the service and a transition took place when possible. Staff had attended the previous placement of the newest person living at the service, to learn how staff there supported them both in managing behaviours and to achieve a fulfilling life.
• The transition had involved the person getting to know staff in their new home, staff getting to know them and information sharing between health and social care professionals and the previous care provider.
• People had detailed support plans that described their needs, wishes and preferences. These were accessible to staff and were reviewed annually or as needs changed.

Staff support: induction, training, skills and experience
• Staff completed an induction when they commenced in post. This involved attending some classroom based learning and online training courses. Training included, safeguarding, whistleblowing, professional boundaries, infection control, health and safety and fire safety.
• Additional in-service training and familiarisation enabled staff to learn local arrangements such as how to complete records, diaries, use petty cash and most importantly become familiar with people's routines.
• Staff received regular supervision. These had been held every two months until 2019 when the provider changed their policy to a minimum of every three months. There had been no recorded supervisions in 2019 however a plan was in place to hold these very soon.

Supporting people to eat and drink enough to maintain a balanced diet
• We saw a photographic menu displayed on the fridge in the kitchen. People chose what they wanted to eat and staff either prepared it for them or supported them with preparing simple meals such as cereal for breakfast.
• Staff were aware that some people needed additional support to maintain a balanced diet. Staff had observed that one person ate more willingly when other people ate with them. Staff had toast with them in the morning to encourage them to have breakfast and ate meals alongside them which had improved the amount they ate.
• One person needed to use the kitchen on their own to prepare food. Staff supported people to give them the space they needed to enable them to maintain their daily living skills.

Adapting service, design, decoration to meet people's needs
• People chose the décor in their rooms and had their own personal items. People living in the service were long-term residents and it was clear that the service had become their home.
• The premises were fully accessible, bathrooms were spacious and if needed could accommodate hoists and other mobility equipment.

• One of the bungalows, which accommodated two people, had sufficient space to provide separate living rooms for each person as they preferred their own space. Each room held items and pictures personal to each individual and one person had drawers filed with activity items they liked to use.
• People living in the bungalows had diverse needs and one person was particularly sensitive to noise. The locality manager told us they would be researching whether having soundproofing fitted was possible to reduce the possible impact of noise on the person.
• Currently there was only one laundry in the two bungalows due to a fire the previous year in the second laundry. The laundry was close to a person that was sensitive to noise. We suggested that the equipment be moved to the other laundry that was not currently in use to minimise discomfort to the person and enable staff to fully access the facility. The locality manager had requested the equipment be moved before we finished our inspection.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to access healthcare services such as their GP and the dentist. Regular check-ups were booked and people were supported to see the GP if unwell.
• The provider was supportive of people's individual needs when attending appointments that may cause them distress. One person was prescribed medicines to keep them calm when attending dental treatments for example.
• The provider also supported people to take minimal medicines. One person had moved to the service taking a wide range of medicines for behaviours. They had worked with the GP to support the person to reduce medicines and now they were on minimal medicines and much more able to manage their behaviours. The provider had implemented the NHS Stopping the Over Medication of People with Learning Disabilities programme (STOMP).

Ensuring consent to care and treatment in line with law and guidance
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.
People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• The provider had completed necessary mental capacity assessments and applied for DoLS authorisations in line with legislation. One person's DoLS authorisation had expired, the locality manager told us that new applications had been submitted the previous week for all residents.
• Care plans clearly indicated the level of capacity each person had and the types of decisions they could make independently and those they may need more support with.
• The provider's policy on managing challenging behaviour differed from that of a person's previous care provider and they were working with in-house behaviour specialists to formulate effective, best practice guidance and support for them to minimise harm to both the person and staff.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence
• We saw a staff member supporting a person to use the kitchen. The support worker remained in the doorway throughout while the person located items and prepared their meal. Staff provided minimal support but were available if needed and enabled the person to be as independent as they could be.
• People could spend time in communal areas such as living rooms or in their own rooms. If they wanted to spend time alone this was fine. One person enjoyed their own company and was enabled to sit on their own however, staff that knew the person well could tell when they wanted company. They were non-verbal however a change in the intonation of the sounds they made and when asked if staff could sit with them, indicating with their hand yes confirmed this.
• We saw one staff member discuss one person when seated in a communal area with them. They spoke about their behaviours in a negative manner across them to a new staff member. The person was clearly affected by this. We told the locality manager about this staff members practice as it did not respect the persons privacy or dignity. All other staff were observed to be respectful and caring towards people.

Ensuring people are well treated and supported; respecting equality and diversity
• The provider had robust statements on equality and diversity which were produced in both standard text and easy read versions containing symbols.
• Staff were friendly and informal with people and were caring and respectful. One staff member had worked with the service for several years and described the home as a family home.
• Staff supported people to access the community and to enjoy themselves using mainstream facilities such as an outdoor gym, parks and the beach.
• On arrival, one person was told to make less noise by staff, this was because they could upset someone in the neighbouring bungalow. The person was 'shushed' which was not respectful nor appropriate as they were not being particularly noisy and they were in their own home.

Supporting people to express their views and be involved in making decisions about their care
• People were supported to make decisions about day to day events such as what to wear and what they wanted to eat.
• Staff knew people well and could interpret words and sounds for us. One person used recognisable words however these did not mean the same to them as others, another person used sounds only. We saw that not all staff were as familiar with people and did not always take on board advice from more experienced colleagues.
• Staff could recognise if someone was frustrated, angry or upset as well as happy and content. Staff recognised if people were becoming challenging and had received training to help them deescalate their behaviours.

• We saw care plans that had been signed by the person or someone authorised to do so on their behalf.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care was planned with people and their relatives to support people as they wanted to be supported. The provider had strived to provide person centred support for a new resident however had not yet achieved this, in part due to having not received full information from their previous placement. Learning that would have been developed over a long period of time, such as the person responding well to wearing a compressions vest, had not been handed over and the person moved to a new environment, was cared for by staff they didn't know well and did not have sensory input in the same way as in their previous placement.
• People were encouraged to participate in activities to stimulate them and to provide fulfilling lives. Staff knew people's interests and which activities they enjoyed participating. We saw people completing table top activities, using a trampoline, doing some art work and going out to shop, for walks and for a drive. Staff knew when to engage people in certain activities when they were becoming unsettled, we saw them take one person for a drive as this was calming to them when the home was noisy or busy.
• There was an activities programme for each person. For example, on the first day of our inspection, one person was shopping during the morning, returned for lunch then had a planned activity in the evening. There was a lot of time during the day that they were unoccupied and during some of this time, two staff members were seated with the person in their living room making no attempt to engage with them. We told the provider about this and they advised us they were reviewing activities and intended to set up additional in-house activities run by support staff.
• The provider understood their responsibilities under the Accessible Information Standard. The Standard requires that services identify, record, share and meet people's needs in terms of how information should be presented to them. We saw photos, symbols, and large print in use however people living in the service appeared to respond well to spoken information.

Improving care quality in response to complaints or concerns
• The provider had a complaints procedure and complaints received would be dealt with in line with the policy.
• The provider was working to improve the experience of one person due to family concerns and evidence their placement was not working well. Contact had been made with health and social care professionals who were supporting with the situation.

End of life care and support
• The provider was not currently supporting anyone at the end pf their life however had systems in place to do so as the need arose.

Requires Improvement

Is the service well-led?

Our findings

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

Requires Improvement: Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

• There had been several changes within the management team over recent months and staff told us this had caused them to feel unsettled and not fully supported. Several support workers had also left the service, some of whom had been long serving staff members which had caused morale in the staff team to become very low.

• Staff told us they had not felt well supported when a new resident moved in. They had received some training in managing challenging behaviour but had needed additional support and more specific training.

• The provider had arranged for the location to be added to another registered manager's portfolio of services, the application had been received by CQC. They had also allocated an assistant locality manager to work in the service to update practices and procedures and an operations manager had been overseeing the running of the service to alleviate concerns from staff and care of people living in the home.

• We spoke with staff on both days of our inspection. On day one, staff were concerned as they had felt unsupported. On day two, the same staff, having spent time with the new management team, were much more positive. One staff member told us, "I feel confident in the management team, and feel confident they can get the service back to where it was, somewhere that was a brilliant place to work and live". Another staff member said, "A month ago we were at rock bottom, now it is much, much better…. we are listened to and that is really important".

• The new management team were aware of their regulatory responsibilities and had submitted notifications about significant events in the service.

• Supervisions or one -one meetings with all staff were being booked and staff were clear as to their role and responsibilities now, whereas before, in the absence of a manager, they were not.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

• The provider was open with us about how they could have provided better, more person-centred support to a new person had they had the full information from their previous provider of care. They were now working with the persons relatives, an in-house behaviour support team and social care professionals to provide a suitable sensory diet for the person to enable them to settle and lead a more fulfilling life.

• The provider planned to update the service provided to people at 123 Calmore Road and offer more in-house activities and a more person-centred service for people living there.

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

characteristics
• People spent significant amounts of time with staff members on a one to one or two to one basis. Staff knew people well and supported them to be involved in decisions in the service as well as they were able.
• Staff had regular staff meetings until 2018 when they became less frequent, we saw only two sets of minutes for staff meetings for 2018. Meetings were now being booked for every month to engage staff with changes to the service and offer support to the team.

Continuous learning and improving care
• The provider had recognised that there were problems with staff morale, high sickness levels and high staff turnover and had introduced a new management team to make improvements. Staff morale affects both staff and people living in the service and we saw improvements to morale over the two days of the inspection as the new management team began to support staff.
• The provider sought to learn from incidents in the service. Accident and incident reports were reviewed by locality managers and the operations manager and any learning that could mitigate future risk was taken and used in the service.

Working in partnership with others
• The provider had forged working relationships with relevant health a and social care professionals enabling people living in the service to access the support they needed.