

Dimensions (UK) Limited

# Dimensions Broomfield 40 Gladstone Road

## Inspection report

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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

This inspection was unannounced and took place on 21 October 2017. At the last inspection on 24 August 2015 the service was rated Good.

Dimensions Broomfield 40 Gladstone Road is a care home registered to accommodate up to three people. The home supports people with learning disabilities and profound physical needs.

There is a registered manager in post. 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.

The registered manager had not notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

The registered manager and provider undertook checks to review the quality of the service provided. However, these did not identify all the shortfalls we found. Where the quality checks identified improvements, these were not always followed up and fully recorded.

Although people's medicines were managed safely, there were some areas where improvements were needed. These included guidance for staff around the use of patches which delivered medicines and creams. Audits had not identified the shortfalls we found.

Staff told us and records confirmed people were kept safe and free from harm. There were appropriate numbers of staff employed to meet people's needs and provide a flexible service.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

There were suitable recruitment procedures and required employment checks were undertaken before staff began to work at the home. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

The staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. These safeguards protect the rights of people by ensuring, if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. This included environmental risks and any risks due to the health and support needs of the person.

The risk assessments we read included information about action to be taken to minimise the chance of harm occurring.

Staff knew the people they supported and provided a personalised service. Care plans were in place detailing how people wished to be supported and families were involved in making decisions about their care.

People were supported to eat and drink. Staff supported people to attend healthcare appointments and liaised with their GP and other healthcare professionals as required to meet people's needs.

Staff told us the registered manager was accessible and approachable. Staff and relatives felt able to speak with the manager and provided feedback on the service.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good ●

The service was safe.

Staff did not have guidance about creams and medicines which were administered through patches. Staff had information in people's records which was not correct. We have made a recommendation about this.

People were protected from the risk of abuse because staff were aware of safeguarding vulnerable adult's procedures.

Staff had guidance about risks to people and these were reviewed regularly.

There were appropriate staffing levels to meet the needs of people who used the service. People were protected from the risks associated with poor staff recruitment because a full recruitment procedure was followed for new staff. There were enough staff to meet people's needs.

### Is the service effective?

Good ●

The service was effective.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of the requirements of the Mental Capacity Act 2005.

People were supported to eat and drink according to their plan of care.

Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required.

### Is the service caring?

Good ●

The service was caring.

Staff were knowledgeable about the care people required and the things that were important to them. They were able to tell us what people liked to do and gave us examples of how they

communicated with people.

Staff were respectful of people's privacy. We saw positive interactions between staff and people using the service. People responded well to staff.

The home had links to local advocacy services to support people if required.

### Is the service responsive?

Good ●

The service was responsive.

People received a personalised service because staff were knowledgeable about their support needs, their interests and preferences

Staff supported people to access the community and this reduced the risk of people becoming socially isolated.

Relatives felt the staff and manager were approachable and there were regular opportunities to feedback about the service.

### Is the service well-led?

Requires Improvement ●

The service was not always well-led.

The registered manager had not notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

The provider did not have effective systems in place to monitor the quality of care and support that people received.

Staff were supported by their manager. There was open communication within the staff team and staff felt comfortable discussing any concerns with their manager.

# Dimensions Broomfield 40 Gladstone 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 21 October 2017 and was unannounced. It was carried out by one adult social care inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

People were not able to give us feedback directly about the care that they received, however we spoke with one relative and made observations throughout the day. We spoke with three staff including the registered manager and assistant manager. We looked at three people's care records and associated documents and observed interactions between staff and people in communal areas. We looked at staff on-line records, previous inspection reports, rotas, audits, staff training and supervision records, health and safety paperwork, accident and incident records, statement of purpose, complaints and compliments, minutes from staff meetings and a selection of the provider's policies.

# Is the service safe?

## Our findings

Staff had information in people's records which was not correct. For example, one person's records said to apply a cream twice daily, however the assistant manager said this had not been the case for at least two months. They told us this cream should be applied on an as required basis. The provider's policy did not give guidance for staff about dating creams on opening, or when they should be discarded. We noted this cream had been opened in March 2017 but was still available for staff to use. This cream should have been discarded as its effectiveness could no longer be guaranteed. Another person's records said to apply a cream daily in one record, but showed this cream as an 'as required' medicine in another record. One person had a cream which was paraffin based, however there was no fire risk assessment for this. This cream had been opened but not dated. After the inspection, the registered manager told us this had been addressed.

There was no guidance for staff about where to apply creams or patches which released medicines slowly through people's skin. However, staff were alternating the site where the patches were put. Guidance for medicines which are delivered through patches will depend on the medicine, so it is important staff should have this information available.

There were suitable secure storage facilities for medicines. People's medicines were stored in locked cupboards in their rooms. On 3 October 2017 we noted the temperature recorded in one person's cupboard was 26 degrees. The provider's policy gave guidance for staff about the actions staff should take if the ambient temperature falls below or rises above those given in the medicines' storage guidelines, and stated, "Generally, the upper limit is 25 degrees C." There was no upper limit identified for the safe storage of the medicines in the cupboard. Staff had not said what actions, if any, they had taken to cool the cupboard down.

We recommend the provider give clear guidance for staff around the use of creams, ointments and medicines patches, in line with good practice.

Medicines were audited on a daily basis. Staff had noticed that a medicines error had occurred and taken appropriate actions. The registered manager had reported this as a safeguarding referral and was awaiting the outcome. The registered manager told us the member of staff concerned would be re-trained and re-assessed.

People's medicines were administered by staff that had their competency assessed on an annual basis to make sure their practice was safe. The assistant manager told us staff completed training and did a two-step competency assessment, which meant they were observed twice, on different days and giving different medicines.

The home used a blister pack system with printed medication administration records. We saw medication administration records and noted that medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know

what medicines were on the premises. We also looked at records relating to medicines that required additional security and recording. These medicines were appropriately stored; however the records for one medicine which had been delivered the previous day hadn't been updated in the controlled drugs register. We checked records against stocks held and found them to be correct. Protocols were in place where people had rescue medicines for epilepsy.

Risks to people were identified using assessments. The assessments we looked at were clear. They provided details of how to reduce risks for people by following guidelines or the person's care plan. Both the care plans and risk assessments we looked at had been reviewed regularly. For example, staff had detailed guidance about the processes to follow for hoisting people and positioning them in bed. This was important to reduce the risks to people if they had seizures in bed. People's epilepsy support plans described the rescue medicines people needed and how staff should support the person. Staff had guidance in place for other risks such as for eating and drinking and people's health.

Major incident contingency plans were in place which covered disruptions to the service which included fire, loss of gas, oil, electricity, water or communications. Business continuity plans were also in place for severe weather. Everyone living in the home had a Personal Emergency Evacuation Plan (PEEP), which gave staff the information they needed to support people if they needed to be evacuated from the building.

Staff told us, and records seen confirmed that all staff received training in how to recognise and report abuse. Staff spoken with had a clear understanding of what may constitute abuse and how to report it. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been brought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected. The registered manager had taken appropriate actions where an allegation of abuse had occurred. Two people's finances were managed by the local authority and one person's family managed theirs. Staff kept clear records and receipts when they took people out.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. The registered manager told us people's care was commissioned by local authorities, who stipulated the number of hours one to one care was needed. Staff rotas showed there were the required numbers of staff on duty.

Risks of abuse to people were minimised because there was a robust recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. Staff told us they had to wait before starting work because the provider had carried out checks with the Disclosure and Barring Service (criminal records check) and obtained references first. Although staff files were not kept on site, the registered manager had access to information on-line which confirmed this.



# Is the service effective?

## Our findings

People were supported by staff who had undergone a thorough induction programme which gave them the basic skills to care for people safely. One member of staff told us they had almost completed the Care Certificate. The Care Certificate is a nationally recognised standard which gives staff the basic skills they need to provide support for people. The registered manager told us everyone completed the Care Certificate unless they had a level three qualification.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff received training to support people's individual needs and had access to information about complex needs such as epilepsy and dementia. Staff said, "We do lots of training, it's all e-learning such as safeguarding" and, "We can ask for additional training if we think we need something." Staff told us they could ask for specialist training if they wished and said, "We could ask for training such as how to become a team leader or a counsellor. I think they're quite willing to provide training." One relative told us, "Staff are very dedicated." The registered manager told us staff had to complete a test at the end of their learning. If staff did not give correct answers to all of the questions, they had to re-do the learning and re-sit the test. This helped to ensure that staff had understood the learning they had completed.

People were supported by staff who had supervisions (one to one meetings) with their line manager. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One member of staff told us, "We have supervisions regularly." The registered manager told us staff were given 360 degree supervisions based on the provider's values, which meant feedback was obtained from everyone, including families and professionals. Staff told us they felt supported by the registered manager, and other staff. Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required. This helped to make sure staff had the required skills and confidence to effectively support people.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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. Staff said, "We assume capacity and always give choices. If people don't have capacity there is a process with paperwork and meetings. Capacity is always decision specific" and "People can make day to day decisions." These comments showed staff worked in accordance with the principles of the MCA to ensure people's legal rights were respected.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had submitted applications for two people and was awaiting the outcome. There were systems in place to record expiry dates and any conditions attached to the DoLS. Although the external access routes via doors and the garden gate were locked, people who had capacity had been given the codes so they could freely exit the premises.

Families where possible, were involved in person centred planning and "best interest" meetings. A "best interest" meeting is a multidisciplinary meeting where a decision about care and treatment is taken for an individual, who has been assessed as lacking capacity to make the decision for themselves.

The registered manager ensured where someone lacked capacity to make a specific decision, a best interest assessment was carried out. Relatives with the appropriate legal authority or people's legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

People were supported on a one to one basis at mealtimes. Risk assessments identified any risks to the person such as a risk of choking. Staff had guidance how to meet people's needs such as the position they needed to be in to enable them to eat and any equipment they needed. Staff used food and fluid charts to record people's intake of nutrients. Everyone required pureed foods; staff had guidance about the correct texture and these were provided as required. People's weights were recorded on a monthly basis unless otherwise stipulated. Where people required nutritional supplements, these were provided. We observed staff assisted someone to eat; this was done appropriately and staff enabled people to be as independent as possible and offered support where required.

People were not able to contribute to menu planning, however staff had obtained detailed information about people's likes and dislikes from their families. Staff also observed people to see their reactions to food offered, and offered alternatives if people indicated they didn't want what was offered. Staff said, "We give them what they like", "You know what they like" and, "When I'm cooking, they're with me and we have a laugh."

People living in the home had complex needs and required support from specialist health services. People's care records showed relevant health and social care professionals were involved with people's care. Care plans were in place to meet people's needs in these areas and were regularly reviewed. People had health action plans and were supported to have annual health checks. Other professionals such as GP's, speech and language therapists, occupational therapists and community nurses were involved in people's care. People had hospital passports which accompanied them in the event they needed to go to hospital. These gave hospital staff the information they needed to be able to continue to provide the care and support the person needed. Staff had specific guidance for monitoring people's health, such as where people might experience epilepsy.

## Is the service caring?

### Our findings

From our observations, we could see that people were relaxed in the presence of staff and appeared to be happy. We saw that staff were attentive and had a kind and caring approach towards people. Throughout the day, as staff moved between the lounge and the kitchen, they took people with them so they could be involved in making drinks and getting food prepared. People appeared to enjoy this, and became animated as staff engaged with them. Staff told us how for one person in particular being involved in everything was very calming for them, and said, "He likes to see what's going on, he's happy if he's involved." One relative told us, "There's a very good feel to the place. Staff are very kind and caring." The registered manager told us, "Staff love these guys; everything they do is for them."

People had care plans which provided staff with the information they needed to ensure people received care which met their needs. For instance, one person's care plan identified that sudden movements or noises could startle the person. Their care plan explained the behaviours the person might exhibit when they were distressed, and gave information what staff should do to help the person. Staff we spoke with were aware of this. Staff also had guidance for supporting people with their paperwork. For example, one person's care plan said they liked to be with staff when the daily paperwork was completed. Their care plan said to put a tray on the person's lap so they could enjoy counting their money with staff. Throughout people's records, information was recorded around what worked for the individual, and what didn't work. Staff knew what would add to the person having a good day or a bad day, and what the person's ideal week would be like.

There were ways for people and their families to express their views about their care. Each person had their care needs reviewed on a regular basis which enabled their families to make comments on the care they received. One relative said, "I'm involved in care reviews, together with other professionals such as a Speech and Language Therapist and staff from the day centre [name] attends." Staff said, "Even though people aren't verbal, they can still let us know what they want" and "You'd know straight away if they don't like something, they'll move away."

People were supported by staff to maintain their personal relationships. This was based on staff understanding who was important to the person, their life history, their cultural background and their sexual orientation.

People received care and support from staff who had got to know them well and were treated with kindness and compassion in their day-to-day care. Throughout the day, staff engaged with people and were attentive to their needs. The relationships between staff and people receiving support demonstrated dignity and respect at all times. Staff told us, and records confirmed, how they ensured people's privacy and dignity were respected. The registered manager told us staff were observed supporting people to check people's privacy and dignity were respected. However, the layout of the building meant everyone had to use one person's bedroom when they wanted a bath. This was because this was the only bedroom with a ceiling track hoist into the bathroom. We discussed this with the registered manager, who said the provider was looking into ways of changing this.

Staff knew, understood and responded to each person's diverse cultural, gender and spiritual needs in a caring and compassionate way. People were supported to attend churches of their choice. Staff showed concern for people's wellbeing in a caring and meaningful way, and they responded to their needs quickly.

People's bedrooms were personalised and decorated to their taste. For example, one person's family had chosen light mauve colours for walls and the room was decorated with pictures from musicals.

The home had links to local advocacy services to support people if they required support. Advocates are people who are independent of the service and who support people to make decisions and communicate their wishes.

## Is the service responsive?

### Our findings

People received care that was responsive to their needs and personalised to their wishes and preferences. People were able to make choices about all aspects of their day to day lives. One relative told us, "They're very keen in doing the best they can to develop [name's] potential." A member of staff said, "You'd know straight away if people didn't like what was being offered."

People's needs were assessed before they began to use the service and reviewed regularly thereafter. People's assessments considered all aspects of their individual circumstances their dietary, social, personal care and health needs and considered their life histories, personal interests and preferences. People had assessments for daily living and long-term outcomes. Care plans reminded staff that all outcomes should be met through positive, individualised support.

People had care plans which gave staff clear guidance how to support the person. People's relatives or significant others were involved in developing their care, support and treatment plans. Staff told us they were also able to contribute to the care plans. For example, care plans were in place for communications, health, mobility, personal care, mealtimes and people's favourite routines. Staff said, "There's good information in care plans" and, "They give us what we need."

Staff knew how people wanted their care to be provided, what was important to them and how to meet people's individual needs. People received personalised care that met their needs. For example, staff had access to care plans which described the behaviours people would exhibit if they were distressed, such as rocking or hyperventilating, and the support the person needed, such as sitting with the person, placing your hands on her shoulders, whispering/talking softly or singing and allowing the person to hold hands. Staff knew about objects of reference for communication, such as using a squeaky yellow duck when it was time for a bath, giving the person a set of keys when they were going out and giving the person the remote control for the hoist when they were going to be hoisted. Objects of reference were used before an activity started, so the person knew what to expect.

People were able to take part in a range of activities according to their interests. Staff had guidance about the person's preferred morning, afternoon and night time routines. People's care plans recorded the hobbies and interests people enjoyed and staff we spoke with knew about these. People enjoyed regular hydrotherapy, attending cinemas, theatres, cafes and pubs which were autism friendly. One relative told us about the holiday their relative had had and said, "There are lots of activities, they take [name] out to church and social occasions." Staff said, "I take [name] out quite a lot, she likes the autistic cinema" and "They're always out and about, they're out more than I am!"

We saw that people and their families had been made aware of the complaints procedures. Complaints were analysed to identify patterns and trends. Information about how to make complaints was available in easy read formats. There had not been any complaints since our last inspection. One relative told us, "I have no concerns." The home also received compliments. One member of staff had been nominated for an award and had been a finalist in the South West Care Awards.

People were not able to give feedback about the service they received, however families were asked to complete an annual survey. The registered manager told us these surveys had only just been completed and the results had not yet been analysed. Healthcare professionals and staff were also asked to give their opinions of the service. The registered manager said, "People aren't verbal so we rely on feedback from staff and families."

## Is the service well-led?

### Our findings

The registered manager had not notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. People had DoLS authorisations in place; these were renewed in July 2017. However, the registered manager had not notified us the DoLS authorisations had been confirmed, or told us about any conditions that applied to them.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider did not have effective systems in place to monitor the quality of care and support that people received. The service improvement plan had not been updated since June 2016. This had identified that staff training and policies and procedures needed to be updated. These had been completed, but remained as actions to complete on the service improvement plan. There were no records of staff having six monthly fire drills, as required by the provider's policy. A health and safety audit completed in October 2017 had not identified any issues. However, information in the health and safety file stated that fire alarms, fire equipment, checks on people's mattresses and checks for carbon monoxide levels should all be checked weekly. The records of fire extinguisher checks did not show they were checked as required. We noted the fire extinguishers were serviced in July 2017. The registered manager said, "The fire extinguishers would have been checked, I believe it to be a recording issue." The records showed the fire alarms had been tested weekly; however one week was missing in October 2017. Carbon monoxide levels and mattress checks had not been done weekly. The information also said that fridge and freezer temperatures should be checked daily. There were no records of these having been done.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The information also said annual PAT testing should be carried out; this is where electrical appliances are checked for safety. However these had not been done since April 2016. After the inspection, the registered manager clarified this with their health and safety advisor, who confirmed the PAT tests only needed to be done every two years. The registered manager told us they had updated their records to show PAT tests are not due until April 2018.

People had been supported to maintain links with the local community through attending various clubs and social activities. Activities available included attending church, being taken out for walks, visiting friends, eating out, shopping and attending a day centre. A music therapist visited weekly and one person enjoyed listening to the guitar. People were able to attend hydrotherapy and a cinema which was autism friendly. Our observations were that people thoroughly enjoyed the activities they took part in and also enjoyed the company of staff who were supporting them.

Relatives and staff had opportunities to feedback their views about the home and quality of the service they received. The registered manager said, "We give staff the opportunity to tell us what needs improving." Families and staff had recently been asked to take part in an annual survey, however at the time of the

inspection the results had not been analysed.

Staff were able to participate in monthly meetings, where they had received health and safety updates, information about training and reminders about the providers' policies.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. This helped to make sure people always had access to senior staff to monitor their health and well-being. Our observations were that people knew the registered manager as well as the staff supporting them. The registered manager also managed two other services and was supported in this home by an assistant manager. Staff had access to a manager at all times; if the registered manager was not working, staff could contact a duty manager.

The provider had a clear vision for the home which was based around their values of respect, integrity, partnership, ambition and courage. Staff we spoke with were aware of the values and told us, "Everything we do is about providing a personalised service." Our observations were that staff put these values into practice as they supported people. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs.

There was a system in place where all accidents and incidents which occurred in the home would be recorded and analysed. There had not been any accidents in the past year.



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 registered manager did not make the necessary notifications.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Records did not show required checks had been completed.