Dimensions (UK) Limited

Dimensions 1 Michigan Way

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?	Good

Summary of findings

Overall summary

Dimensions 1 Michigan Way is located in a residential area and provides accommodation, care and support to a maximum of five people with a learning disability. The service provides support to mainly older adults.

This inspection took place on 19 September 2017 and was unannounced. There were five people living in the home.

The service had a registered manager in post. A registered manager is a person who has registered with 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.

There was a friendly atmosphere in the home and staff supported people in a kind and caring way that took account of their individual needs and preferences.

Staff understood how to identify, report and manage any concerns related to people's safety and welfare. There were systems and processes in place to protect people from harm, while promoting their independence.

Safe recruitment practices were followed and appropriate checks had been undertaken, which made sure only suitable staff were employed to care for people in the home.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and competency assessments.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

People were supported to eat and drink enough to meet their needs and to make informed choices about what they ate.

People and their relatives or representatives were involved in planning the care and support provided by the service. Staff listened to people and understood and respected their needs and wishes.

The service was responsive to people's needs and there were systems in place to help ensure any concerns or complaints were responded to appropriately. Healthcare professionals were involved in people's care when necessary.

The provider and the registered manager were promoting an open and inclusive culture and continued to look for ways to improve the service. There was a range of systems in place to assess and monitor the quality and safety of the service and to help ensure people were receiving appropriate support.

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.

People were protected from the risk of harm or abuse because staff understood their responsibilities.

Risks to people's individual health and wellbeing were identified and care was planned to minimise the risks.

There were sufficient numbers of staff to meet people's needs. The provider checked staff's suitability for their role before they started working at the home.

Medicines were stored, administered and managed safely.

Is the service effective?

Good

The service was effective.

People were cared for and supported by staff who received relevant training and supervision.

The service followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

People's nutritional and dietary needs were taken into account in menu planning and choices.

People were referred to other healthcare services when their health needs changed.

Is the service caring?

Good

The service was caring.

Staff had developed positive caring relationships with people using the service.

Staff knew people well and respected their privacy and dignity.

Staff promoted people's independence and involved them as

much as possible in making decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

Staff had a good understanding of people's needs, choices and preferences, and the knowledge to meet people's individual needs as they changed.

There was a process in place to deal with any complaints and people were supported to express any concerns.

Is the service well-led?

Good

The service was well-led.

The registered manager and the provider promoted an open, inclusive and empowering culture.

People, their families or representatives and staff had opportunities to feedback their views about the home and quality of the service being provided and this was used to drive improvements.

The quality of the care and treatment people experienced was monitored and action taken to promote people's safety and welfare.

Dimensions 1 Michigan Way

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. The inspection was planned to check whether the provider was 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.

We visited the home on 19 September 2017. The inspection was carried out by one inspector and the inspection was unannounced.

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 also checked other information that we held about the service and the service provider, including notifications we received from the service. A notification is information about important events which the provider is required to tell us about by law.

During the inspection visit we spoke with the registered manager and four members of staff. Although we were not able to have in depth conversations with people living in the home who we met, we were able to observe staff interacting with people. We looked at a range of documents and written records including people's care records, staff recruitment files and training records, risk assessments and medicines charts. We also looked at information regarding the arrangements for monitoring the quality and safety of the service provided within the home.

Following the inspection we attempted to contact a person's relative but were unable to do so. We asked three community health and social care professionals for their views about the service and received feedback from two of them.

The home was last inspected in February 2016 when two breaches of the regulations were identified in relation to assessing and managing risk and monitoring the quality and safety of the service. The provider had sent us an action plan and at this inspection we saw that the improvements had been made.

Good

Is the service safe?

Our findings

At the previous inspection we found that some risks to people's health and wellbeing had not been adequately assessed and planned for. Risks in relation to dysphagia had not been reviewed following a significant incident within the home. (Dysphagia is the medical term for swallowing difficulties). The provider had introduced national guidance but within the service there was no evidence this had been followed or staff had received training. Therefore risks to people's health and well-being had not been mitigated.

Following the inspection the provider took immediate action to ensure that the correct updated support guidance was available in both a person's care plan and the kitchen area to guide staff on food preparation. The provider also sent us an action plan showing how they would ensure further improvements were made and embedded.

During this inspection we saw evidence that the improvements had been made. Risk assessments had been reviewed for all of the people in the home including screening by a speech and language therapist (SALT). The provider had implemented new support plans to promote safer swallowing for anyone at risk and monitored the review of these plans. Staff we spoke to during the inspection were aware of the policy and guidance and were able to explain what actions they would take if an incident of choking occurred.

Information and visual prompts in relation to people's individual dysphagia and dietary requirements, the first aid procedure for choking, and a list of 'never events' were clearly displayed in the kitchen and office. Staff had received relevant training, including emergency first aid. Agency staff received the same induction into the service as regular staff, which included risk assessments, never events and safeguarding information.

Discussion about risks was a fixed item on the staff meeting agenda. Staff had developed an anagram to help ensure everyone working in the home understood the provider's guidance on events that should never happen. These 'never events' included people coming to harm as a result of incidents relating to medicines, equipment, epilepsy, training, choking and healthcare. Staff we spoke with were all aware of the guidance about 'never events'.

People were supported to take planned risks to promote their independence. We saw a range of risk assessment and management plans which provided relevant guidance for staff, for example when supporting people in the community. Staff were able to tell us about the risks associated with certain situations and people. They gave us consistent answers demonstrating they knew people well. Falls and seizure monitoring procedures were in place for some people and staff were knowledgeable about these.

There was an up to date fire risk assessment and records were kept of regular checks and tests of the fire alarm, emergency lighting and fire safety equipment. Fire safety instruction and drills for all staff were recorded including timed practice evacuations. Each person had a personal emergency evacuation plan, which included important information about the care and support each person required in the event they

needed to evacuate the premises. Staff carried out weekly recorded audits including health and safety checks, medicines audits and water temperature tests.

There were enough staff to meet people's needs and provide care and support with activities. Staff were present when people spent time in the communal areas and people who were spending time in their rooms were suitably supported. The rota showed how staff were deployed to provide the commissioned support hours and meet each person's needs. There were three care staff on duty on each of the early and late day shifts. Each person also had additional staff support time hours that were used flexibly to suit their activities. One awake and one asleep/stand by staff were on duty during the night. An on-call system was in place to deal with emergencies including any unforeseen staff shortages.

A system was in place to keep track of and record relevant checks that had been completed for all staff who worked in the home. We looked at the records of two staff recruited since the last inspection. These included written references, employment histories, and satisfactory Disclosure and Barring Service (DBS) clearance. DBS checks are carried out before potential staff are employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people. These measures helped to ensure that only suitable staff were employed to support people who used the service. In addition, the registered manager used staff supervision meetings to check that staff DBS, identity badges, documentation relating to the right to work, driver authorisation and insurance, were in place and up to date.

People's medicines were stored securely and at safe temperatures and managed so that they received them safely. Up to date records were kept of the receipt and administration of medicines and any unused medicines were signed for and disposed of by the pharmacist. A weekly audit of medicines was completed by a senior member of staff which included a stock check to ensure all medicines were accounted for. Spot checks were also carried out by the management team. There were detailed individual support plans in relation to people's medicines, including any associated risks. Guidelines were in place for when prescribed 'as required' (PRN) medicines should be given and a member of staff demonstrated their knowledge of these.

Staff received training in the safe administration of medicines and this was followed by competency checks. If a member of staff was identified as making a medicines error, an incident form was completed and the member of staff was required to complete a reassessment, in order to support learning and safe practice. The training included training in epilepsy awareness and administering medicines for the treatment of epileptic seizures. Staff explained the procedure and showed us records for checking and signing in and out of medicines for the treatment of epileptic seizures, which staff would take with them when supporting a person in the community, or which would be signed out to relatives when the person visited them.

Good

Is the service effective?

Our findings

Staff had received regular training to enable them to provide effective support to people, such as moving and handling, fire safety, infection control and first aid. Additional training was provided for staff around people's specific needs, such as dementia awareness, epilepsy, and diabetes. Staff were also supported to undertake vocational qualifications in care in order to further their professional development. New staff completed an induction that included working alongside experienced staff as well as completing the Care Certificate, where required. The Care Certificate is a nationally recognised set of induction standards for health and social care staff. Prospective staff were required to complete a literacy and numeracy test.

A system was in place to track and record the training that each member of staff attended. The registered manager had introduced reminders for staff in relation to when training updates were due and told us staff were now taking ownership and responsibility for this. The provider also set criteria for services complying with training targets and the service was within this.

Staff received supervision and appraisals from their line manager, which provided them with formal opportunities to discuss their work performance, any training needs, ideas or concerns, and to receive feedback. The registered manager also used supervision meetings to ask staff about what was working and not working well within the service. Action plans were developed and followed up at subsequent meetings. Staff confirmed they were well supported and could ask for advice or guidance when they needed to.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. Mental capacity assessments had been completed appropriately and best interest decisions made with the involvement of relevant others. Health and social care professionals said staff took into account people's mental capacity and consent and "Supported them to be involved in all decision making". They told us staff were "Working within best interests, due to a client's dementia, with some decisions as he lacks capacity".

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). The provider had applied for appropriate authorisation where required. Where necessary restrictions were in place, these were documented in people's support plans. The application for one person had been authorised with a recommendation that staff liaised with the community health team about continued health monitoring and this had taken place.

Staff prompted and encouraged people to make choices about what they ate and people appeared to enjoy their meals. Two people used specially adapted utensils to assist them to eat independently. Records were kept so that the service could monitor people's diet and nutrition. Staff maintained a presence while people

at risk of choking were eating and recorded their observations of mealtimes. Staff provided any support required and chatted to people which helped make the mealtime a social event. Staff demonstrated knowledge of people's individual support needs and associated risks in relation to eating and drinking. This included explaining how to use the correct amount of thickener in a person's drinks in line with the support plan.

People had Health Action Plans and received regular and on-going health checks and support to attend appointments. This included reviews of the medicines they were prescribed, GP and dental appointments. People also had a hospital passport in readiness should they require hospital treatment. The aim of a hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

Staff were proactive in requesting visits or reviews from health professionals, such as GP's or other health care professionals. Staff recorded all contacts and visits from health professionals in people's care plans and followed up any appointments where required. The registered manager told us the service had a good relationship with the local GP surgery. Health and social care professionals confirmed people were supported to maintain good health. One community professional said "Staff regularly consult with the client's GP to ensure he has access to good health care for his multiple conditions".

Good

Is the service caring?

Our findings

A health and social care professional told us "Staff engage well with people and involve them in day to day life and decisions". Another health and social care professional said staff "Involved a client with making choices; gave him time and adapted their communication style and environmental cues to help him choose a riser recliner chair colour and fabric". They also commented Staff "Use humour and interact in a warm and affectionate way".

Staff had developed positive caring relationships with people using the service. The atmosphere in the home was friendly and supportive and we observed staff knew people well and communicated effectively with them. We observed a person enjoying a balloon game initiated by a member of staff. The person was laughing and very engaged in the activity. The member of staff continued to offer various activities that they knew the person had previously shown an interest in. A member of staff told us "We've got a small, tight knit team here" and "A happy staff team is an effective staff team".

The relationships between staff and people receiving support demonstrated dignity and respect. Staff spoke about people in a respectful manner and demonstrated understanding of their individual needs. People's care and support plans were written in a respectful way that promoted their dignity and independence. The registered manager and a member of staff had received training to take lead roles in promoting people's dignity within the care setting.

Staff supported people to stay in touch with people who were important to them. For example, one person was supported to maintain regular telephone calls with their family. Staff had recently managed to support another person in getting back in touch with their family. A member of staff said "We try to involve people's families and to make it as homely as possible".

People were supported to do the things that interested them and to participate in community activities. People's activities included day services and individual interests, for example one person liked staff to take them for drives on the motorway. People were also supported to have holidays, for example one person was going on holiday to Blackpool supported by a member of staff. The registered manager told us another person had recently been supported by staff on "a trip of a lifetime" to America, as the person had wanted to visit Washington DC.

People were encouraged to express their views and be involved in making decisions about their care and support. We observed a person chose to go to the beach instead of a previously planned activity with another person. Person centred planning meetings were held with the involvement of the person's family and/or other representatives including day service staff, advocates and other external professionals. People's care and support plans included guidance to assist staff to involve the person and help them with everyday decisions. For example, how best to present information and ways to help the person understand. Staff had spent time with people, involving them in discussions about their goals, activities, care and support.

Good

Is the service responsive?

Our findings

The service worked in partnership with multi-disciplinary community teams to support people with complex needs. A health and social care professional told us "Staff have adapted to the changing needs of individuals" including a person who was living with the onset of dementia. Another health and social care professional said staff were "Keen to support the client in their current home and adapt to changes". They said the service worked with them to support a person whose ability to mobilise, understand and engage in everyday activities was deteriorating. The service was "Keen to include the health team to advise on best care and engagement in order to improve and maintain a client's quality of life and health".

A personalised approach to responding to people's needs was evident in the service. Before people moved to the service an initial assessment of their needs took place to help ensure the service was suitable for them. People and their relatives or representatives were encouraged to be involved in this process. Following the initial assessment a care and support plan was developed that was tailored to the individual, reflected their personal preferences and how they expressed themselves and communicated with others. Staff demonstrated knowledge of people's individual needs, personalities and preferences. There was a relaxed atmosphere in the home and staff communicated well with the people and promoted an inclusive, supportive environment.

One person who had recently moved into the home from another of the provider's services had already known one of the people living at the home and interacted positively with the others. An occupational therapist was involved in assessing the person's care and support and providing advice and guidance for staff. The registered manager and staff told us they tried different ways to engage and motivate the person during personal care, including singing to them. A system of staff rotation was used as this had been identified through observation to help keep the person engaged.

Assistive technology was sourced and provided to meet people's assessed needs. For example, mechanical chairs, profile beds and epilepsy sensors. Vibrating fire alarms and flashing beacons had also been supplied for two people who had hearing impairments.

Staff monitored people's changing needs through a system of regular reviews and observation and this was clearly recorded. Each person had a key worker, a named member of staff who participated in reviewing the person's care and support with them on a monthly basis. This helped to ensure care and support plans were current and continued to reflect people's preferences as their needs changed. Staff were prompt to raise issues about people's health and people were referred to health professionals when needed. A communication book and handover meetings between shifts were used to communicate any information amongst staff about each person for that day.

Information about the service was provided in easy to read formats including, for example, the provider's policies on how to make a complaint, bullying and hate crime. Staff understood people's needs well and demonstrated how they would be able to tell if a person was not happy about something, which meant that people would be supported to express any concerns. The service had received one complaint since the last

inspection and this had been responded to and resolved within the timeframe of the provider's policy and procedure.

Good

Is the service well-led?

Our findings

At the previous inspection we found that there were a range of systems in place to assess and monitor the quality and safety of the service. However these had not always been effective and had not ensured that staff had the information they needed to mitigate risks relating to people's safety. The provider sent us an action plan showing how they planned to address the issues.

During this inspection we found improvements had been made. The provider and registered manager had introduced a range of visual aids to help ensure staff had the information they needed to provide appropriate care and support. Staff meetings and supervisions had been used to ensure staff were aware of and adhered to current guidance for supporting people. Staff attendance of training was monitored more effectively and performance management systems were in place. The service had worked in partnership with external health and social care professionals to review people's risk assessment and management plans. Regarding the changes that had taken place in the service since the last inspection, one member of staff said "You can't get too comfortable. We're all on the same page now. We all know what to do".

A health and social care professional told us "I believe the service has a strong and consistent staff team including seniors and is well managed". Another health and social care professional confirmed the service delivered good quality care.

The service promoted an inclusive and empowering culture. The provider's quality audit team included a 'quality checker', a person receiving support from one of their services, who provided feedback. Events were held to provide opportunities for people using services, families and staff to meet and talk with senior management. Staff team meetings were held in general every two months, for which there was an agenda that always included health and safety matters and provider updates. A member of staff said they felt listened to by the management team. For example, discussing a person's mobility needs resulted in contacting an occupational therapist and ordering new equipment. They felt the culture within the service promoted openness "with everyone". A team building day had taken place in June 2017 and staff spoke positively about this.

People and their relatives or representatives were given the opportunity as part of their annual review to complete a survey about the support they received. The survey included questions about, for example, the support people received to keep in touch with and spend time with people who were important to them; being offered choices and making decisions; feeling safe, healthy and well; and getting support to do things that were important to them and to try new things. The provider published a summary of stakeholder feedback they had received. This included the findings in relation to what services needed to get better at, such as people making decisions and choices about their care and support and choosing who supported them.

Actions developed from feedback formed part of the provider's national and regional delivery plans. In Hampshire and Dorset, involving people in choosing the staff who will be supporting them was a key part of the regional delivery plan. Another priority was making sure people had accessible information. These and

other relevant matters were raised in house meetings and covered in local events. We saw a letter sent to people with the outcomes from a local listening event in June 2017. The letter was written in an easy to read 'what you said, what we will do' format. The outcomes included supporting people with their health needs and looking at how services could work with health professionals so they understood people's needs better. Another outcome was about looking at increasing efforts to recruit staff and involving people in different ways to help them choose their staff.

At the time of our visit the registered manager was meeting a recently interviewed new member of staff for a 'meet and greet' in order to further assess their suitability for the role. As part of this process, people living in the home were given the opportunity to meet the new member of staff and to ask them questions before they started working as a new member of the team.

The registered manager told us the provider audits, which used to take place four times a year, were now carried out annually and more in depth in the form of unannounced inspections over the course of two days. The last one of these audits had taken place in May 2016 and an action plan had been developed to make further improvements in the service. Actions had been completed in line with the plan, for example, updating support and health action plans and making more effective use of staff. Rotas had been changed to deploy more staff at busier times during the day and less in the evenings when people were less active. Other recent developments included improvements to the outdoor space and garden; and people being more actively involved in their care and support. The registered manager had contacted the housing provider following which improvements had been made to a wet room.

As part of a drive for continual improvement, the provider was developing services further through introducing new technologies and evidence based support systems, working in partnership with Kent University. Within the provider's services locally, the registered manager was taking a lead role in an initiative to ensure people's medicines were kept under review.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.