Dimensions (UK) Limited

Dimensions 8 Queens View Crescent

Inspection report

8 Queens View Crescent
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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

Overall summary

This unannounced inspection took place on 13 February 2015. At the last inspection on16 July 2013, the registered provider was compliant with all the regulations we assessed.

Dimensions 8 Queens View Crescent is a purpose built single storey home for up to six people with a learning disability. It is situated in a residential setting and close to local facilities. The home has six single bedrooms, a bathroom, a kitchen, a laundry and a large lounge/dining room. There is a garden at the rear of the property and car parking at the front. At the time of the inspection there were five people living in the home.

The registered provider is required to have a registered manager in post at Dimensions 8 Queens View Crescent. We found the manager had been registered with the Care Quality Commission since 30 January 2012. A registered

Summary of findings

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.

We found people lived in a safe environment where equipment was serviced and safety checks were carried out. Risk assessments were completed to help minimise risk in specific circumstances such as when supporting people in the community or with day to day support within the home.

There were policies and procedures in place to guide staff and training for them in how to keep people safe from the risk of harm and abuse. In discussions, staff were clear about how they protected people from the risk of abuse.

There was a good recruitment system in place, which meant checks were carried out before new members of staff could start work at the service. There were sufficient staff on duty day and night to meet people's needs. There were additional staff on specific days to support people with activities outside the service. We found the staff approaches to be caring and friendly. People told us they liked the staff that supported them and we could see they had been helped to maintain important relationships with their family.

People had their health and social care needs assessed and personalised support plans were developed to guide staff in how to care for people who used the service using the least restrictive options. People received their medicines as prescribed and had access to a range of professionals for advice, treatment and support.

People's nutritional needs were met. Staff monitored people's food and fluid intake and took action when there were any concerns. People were supported to shop for food supplies and some people were assisted to prepare meals.

People who used the service were encouraged to make their own decisions. Staff followed the principles of the Mental Capacity Act 2005 when there were concerns people lacked capacity and important decisions needed to be made.

People accessed a range of community facilities and also completed activities with the service. They were encouraged to follow hobbies, social interests and to take holidays.

There was a range of training and support systems in place to ensure staff were knowledgeable and skilled in supporting people who used the service.

There were systems in place to monitor the quality of the service, such as observations of staff practices, audits and surveys. There was a complaints policy and procedure and people told us they felt able to complain and raise concerns.

Information about the services provided to people was all written in easy read format. This helped to make the information accessible to people.

Summary of findings

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.

There were policies and procedures to guide staff in how to keep people safe from harm and abuse. Staff had completed safeguarding training and knew how to respond to concerns.

Staff were recruited safely and there were sufficient staff on duty to meet people's current needs. Staff knew how to respond to emergency situations.

People received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

Peoples health care needs were assessed and met. They had access to a range of health care professionals for advice and treatment.

The meals provided to people who used the service were balanced and met their nutritional needs. People were consulted about meals and provided with choices and alternatives.

Staff were supervised by management and provided with training opportunities to ensure they developed the skills and knowledge required to support people.

Good

Is the service caring?
The service was caring.

Staff had developed positive and caring relationships with the people they supported.

People had their privacy, dignity, choice and independence promoted by staff.

People were involved in decisions about their care and support and were encouraged to maintain relationships with their family.

Good

Is the service responsive?
The service was responsive.

People had assessments of their needs and personalised care plans which staff followed in order to provide the care and support people required and preferred.

People who used the service were encouraged and supported to access community facilities and to participate in activities of their choosing.

There was a complaints process and documentation on how to complain in an easy read format. This helped to make the documents more accessible to people who used the service.

Good

Is the service well-led?
The service was well-led.

The culture of the organisation was open and inclusive. People who used the service and staff were provided with opportunities to express their views about how the service was managed.

Good

Summary of findings

Staff worked well as a team and told us they felt able to raise concerns in the knowledge they would be addressed.

There was a system in place to monitor the quality of the service provided to people. Audits were carried out and action plans produced to meet any identified shortfalls.

Dimensions 8 Queens View Crescent

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 registered 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.

The inspection took place on 13 February 2015 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection, we asked the registered provider to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we observed how staff interacted with people who used the service. We spoke with one person who used the service and three people's relatives. We spoke with the registered manager and three care support workers. We also received information from a social worker who visited the service.

We looked at three care files which belonged to people who used the service. We also looked at other important documentation relating to the five people who used the service such as their medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documentation relating to the management and running of the service. These included two staff recruitment files, training records, the staff rota, minutes of meetings with staff and those with people who used the service, quality assurance audits and maintenance of equipment records.

Good

Is the service safe?

Our findings

One person we spoke with told us they felt safe living in the service. They said, “I like living here” and “They look after me.” Relatives told us there were enough staff to support people in meeting their needs and staff knew how to keep people safe. Comments included, “Oh, absolutely they keep X safe”, “They are very safe there; I have no concerns at all” and “There seems to be enough staff.”

There were policies and procedures to guide staff in how to protect vulnerable people from the risk of harm and abuse. The company had a ‘whistle blowers hotline’ so staff could report any concerns anonymously if they chose to. It was clear from discussions with staff that they knew the different types of abuse and how to respond if they witnessed incidents of harm or abuse. Staff confirmed they had completed safeguarding training. The registered manager knew the process for alerting the local safeguarding team of any incidents of harm or abuse and we had received notifications as required. The registered manager said, “I ring the Safeguarding Team for advice. I still fill in an alert form even if the incident is low level on the safeguarding threshold indicator and submit them following the incident.” They also said, “All staff have had safeguarding training; we discuss it in one to one’s and team meetings.”

There were systems in place to protect people’s monies deposited in the home for safe-keeping. This included individual records, two signatures when monies are deposited or withdrawn and weekly audits.

Risk assessments had been completed for people when specific areas of concern had been identified. These guided staff in how to minimise risks and included areas such as choking, eating and drinking, falls, moving and handling, epilepsy management, the use of bedrails and bathing. There were additional risk assessments for activities in the community such as swimming.

We saw medicines were managed well and people received their medicines as prescribed. The medicines file held medication administration records (MARs) to record when medicines were given to people and when they were omitted. There was a list of medicines used and their side effects, important information about any allergies, and how people communicated they were in pain and may require pain relief. There was also information on how people took their medicines. For example one information sheet stated, “They take their medicines off a spoon with jam or yoghurt” and another stated, “They take them from a pot with a drink of water.” Training records showed us staff had completed theory and practical medicines management training to ensure they had the skills required to administer medicines safely.

We found there were sufficient staffing numbers to meet people’s current needs. There were two staff on duty during the day and one at night. Additional staff were in place to support people for one to one activities. The staff were able to call on support from members of staff at the two other services the registered provider had, which were in close proximity to 8 Queens View. There were management on-call systems out of usual working hours and the registered manager told us they could use agency staff when required.

The registered manager told us staff recruitment was underway due to some gaps in staffing currently filled by agency staff. Recruitment files checked showed us staff were only employed after appropriate checks had been carried out such as references and the disclosure and barring service. Potential new staff attended for an interview and the assessment continued when they were introduced to people who used the service to monitor communication skills and their ability to establish rapport.

We found there were systems in place to respond to emergencies that could occur. For example, each person who used the service had a personal emergency evacuation plan. Staff had completed first aid training and there was a first aid kit in the service. The close proximity of the registered providers other services meant these could provide temporary support in emergency situations.

We saw checks were made to ensure the environment was safe and a member of staff had a designated lead role for health and safety. Checks included slings for the hoist, hot water outlets and fire alarm equipment. Moving and handling equipment was maintained and serviced as required. Electrical appliances and kitchen equipment were checked to ensure they were safe to use. There were quarterly checks on the hot water system and a legionella risk assessment had been completed.

Good

Is the service effective?

Our findings

One person who used the service told us they liked the meals provided. They confirmed they had choices about meals and had plenty to eat and drink. Relatives told us they had seen the meals provided to people. One relative said, "I have seen them prepared; they looked and smelled nice and everyone cleared their plates." Another relative said, "The meals are lovely; there is good choice and variety and they make sure X's weight is stable."

Relatives told us they thought staff were well trained and were able to meet the range of people's needs. When asked if they thought staff had the right approach and sufficient skills to support people, one relative said, "Not half; staff look at instructions (care support plans) and the information book to see what has happened and what they need to do." Another relative said, "Yes, I do think they are trained well. They work well together and share information."

We found people's heath and social care needs were assessed, planned and met. Each person had a health action plan in pictorial format, which detailed the support they required from health care professionals in the community. There was a log maintained of contact with health professionals and we saw these included specialist community nurses, opticians, dentists, dieticians, speech and language therapists and physiotherapists. People were also supported to see their GP and consultant when required. Staff described how they had received a screening kit for one person who used the service, which involved returning a specific sample. They said it was important health screening was completed in a timely way so that action could be taken as required. A professional who visited the service said, "They are good at communicating with me."

In discussions, staff demonstrated knowledge of people's health care needs and described how they recognised when they developed symptoms that required follow up with health professionals. They said, "We always know when X is getting poorly, they act out of character and go off their food", "Deterioration in health varies for each service user, for example X stops being chatty; we know our service users and what is different from usual" and "None of our service users have DNR's (forms to alert people that resuscitation is not to be attempted) in place so they would all be resuscitated if they collapsed." These measures told us staff took the health care needs of people who used the service seriously and supported them to maintain their health as much as possible.

We saw people received balanced and nutritious meals, which helped to maintain their weight. There was a menu board near the kitchen which described in pictorial format what the choices were for meals each day. Staff told us they were relaxed about this and as there were only five people who used the service, they were able to provide alternatives if people changed their minds about the meals on offer each day. There were care plans that described the support people required with eating and drinking and any measures in place to reduce risks such as choking.

Staff described how specific people who used the service liked to shop for groceries and help prepare some of the meals. They said they had an ample budget and at the beginning of each week spoke with people who used the service about suggestions for lunches and evening meals.

We observed most people were independent with eating their meals or just required prompting and supervision. When people did require support to eat and drink, this was completed sensitively and at an appropriate pace. Staff sat at the dining table with people to eat their own meal at lunchtime. This helped to encourage people to eat their meals and enabled staff to provide support to people in a way that was unobtrusive. We saw people had drinks throughout the day and not just at set times; some people were able to go into the kitchen and make their own hot drinks. This was encouraged when it was safe for them to do so.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities in relation to DoLS and had made applications to the local authority but these had not been finalised and authorised as yet.

Staff had received training in the Mental Capacity Act 2005 (MCA) and they were clear about how they gained consent to care and support prior to carrying out tasks with people who used the service. Staff told us most people were able to make day to day decisions about their support. They

Good

Is the service effective?

said, “Only X is not able to give consent on a daily basis so we use body language and facial expressions; they have a care plan that gives us guidance, likes, dislikes preferences are all written in there.” There were records of assessments under MCA and best interest meetings had been held when people were assessed as lacking capacity to make important decisions. Discussions had been held with people’s family regarding the use and payment of two vehicles, which were for communal use by people who lived in three services managed by the registered provider. The records of the outcome of these discussions could not be located during the inspection. Some people were able to use the vehicles more often than others but all paid the same amount each week for the upkeep of them. This was not an equitable system and we have asked the registered manager to complete analysis of this, review the system and keep us informed of the outcome.

Records showed us staff completed an induction and they had access to a range of essential training and also training which was specific to the people who used the service. Records were held on a computerised system and we saw this was updated when training was completed; the system indicated when refresher courses were required. The registered provider’s learning and development team organised the training courses but requests for individual and specific training could be made. The registered manager said, “All staff can get onto a portal system to see what training is due; we try to encourage staff to take responsibility for it.” In discussions, staff confirmed they received training which enabled them to feel confident and skilled when supporting people. They said, “We have on-line training and practical training; we see the manager if we want to make suggestions about training.” Staff told us one person had responsibility for health and safety within the unit and carried out fire drill training. They said, “The last fire drill was last week; they do checks with staff and service users and talk them through what they would do.”

Staff told us they felt supported and received supervision in meetings with their line manager. They said, “We have good management support; they are approachable” and “We have six-weekly supervision; they do listen and I do feel supported.”

The environment consisted of a single storey building and met people’s current needs.

Good

Is the service caring?

Our findings

One person told us staff treated them with kindness. They said, "The staff are nice" and "They take me to the shops." Relatives told us the staff team knew people's needs very well. Comments included, "The staff are really kind", "They are very caring", "The staff are very good; I feel X is very well looked after, "They are committed, dedicated and have got to know all X's little ways" and "The staff are brilliant and spend so much effort with X."

Relatives told us the staff supported their family member to maintain relationships with them and to visit when possible. They said they were kept informed about important issues that affected their relative and were invited to review meetings to discuss the care provided to them. One relative said, "They always ring me to keep me informed" and another said, "They bring X to see me" and "They rang me to tell me X was doing alright and that a specialist nurse had been to see them."

We observed positive interactions between staff and the people they supported. There was a key worker system where people who used the service were allocated specific members of staff to support them. The staff took time to build up relationships and trust with people and their families, they helped to formulate their plans of care and assisted them in daily living tasks. In discussions with staff it was clear they had a good understanding of people's needs, their wishes and preferences. We overheard staff spoke to people in a polite and friendly way and they provided explanations prior to tasks. For example, during support to eat their meals at lunchtime and when escorting people into the community.

There were notice boards in the sitting room and near the kitchen. These provided information to people who used the service about activities and the meals available each day. There were symbols and pictures to help people understand the information. Staff told us they consulted with people on an on-going basis about the activities they wanted to do and the meals they wanted to eat. Staff told us meals were planned from these discussions but were always open to change; we observed this in practice during the inspection. We saw there were specific policies, procedures and records in an easy read format such as the complaints procedure and review of care plan documentation.

In discussions, staff were clear about how they promoted people's independence and choice. They also described the ways they supported people to maintain their dignity and privacy. Comments from staff included, "Some service users help to prepare meals and some are able to make their own drinks", "We always ask people so they have choices", "Knock on doors, close doors and keep people covered up during personal care tasks" and "X likes to pour milk onto cereals; as long as we take lids off X is independent with this." Some people who used the service shopped for groceries with staff support and completed household tasks such as tidying their bedroom and sorting out their laundry.

A professional who visited the service said, "My observations are that my client is treated with dignity and their choices are respected. They listen to requirements." They also said, "Staff interact well with clients; there's a good atmosphere in the house."

We saw care plans contained, "Getting to know me" information. This covered information about likes and dislikes, and preferences for how the person wished to be supported. The information was collated from discussions with the person, their relatives and observations from staff who supported them. This showed us people were involved in the planning of their care. Bedrooms had been personalised and staff had involved people when choosing colour schemes and decoration.

Documentation showed that one person had used an advocacy service to support them to make decisions during reviews of their care. Other people had the support of relatives.

We saw there were policies on data protection and confidentiality. Staff signed to say they had read and understood these policies. This meant staff were provided with guidance on how to protect confidential information. We saw staff completed telephone calls to health professionals of relatives in an office to ensure conversations were not overheard.

Good

Is the service responsive?

Our findings

People told us staff looked after them and they felt able to complain if they were unhappy about the service. One person who used the service said, “They (staff) are alright” and “I’d tell X (staff) and they would sort it.” Relatives were very complimentary about the care provided to their family member and were pleased about the activities they participated in. They said, “I think they know X’s needs better than I do now after all these years” and “They try to take people out shopping and to the supermarket. Regular carers take X to Scunthorpe for a walk around and I know they have trips out in the evenings. They go to Cleethorpes for fish and chips.” One relative mentioned they would like to see their family member have more trips out into the community. They said, “X does get out but from time to time I think they struggle due to staffing; staff enable X to do what they want to do.” Relatives told us they felt confident any complaint would be addressed.

A professional who visited the service said, “Yes, my clients needs are met very well and they are well supported.”

We saw records of assessments, risk assessments and care support plans. These were person-centred and included important information about how the person preferred to be supported by staff. For example they included documents titled, “What's important to me”, “How best to support me”, “What’s working and not working”, “What a good day and bad day looks like”, “My perfect week schedule” and “How do I want my life to be.” We found these were completed in detail and information had been gathered from discussions with the person they were about, their family and from staff observations when they supported people. The care support plans indicated what the person was able to do for themselves so that staff were able to encourage the person to maintain these skills. For example, we saw entries such as, “Can brush their own teeth”, “Go at their own pace” and “X will wake up when they are ready.”

Each person had a personalised health action plan. This detailed how they were to be supported to maintain their health and wellbeing and which health professionals were involved in their care and treatment. Staff supported people when they were transferred from one care setting to another to make this as smooth as possible. For example, important information was written in a ‘patient passport’ and held on the person’s support file in case of hospital admissions. One relative told us, “When X went into hospital they couldn’t have given them better care. Staff went to the hospital and stayed with X until they went to sleep. They kept going back and forth to the hospital to see X”

Reviews of care were person-centred and records of them were in easy read format. This helped them to be more accessible to the person they were about. The record of the review included what the person had tried during the time frame, what had been working well for them, what could be better and what they wanted to do next. During the inspection, a review of one person’s care was taking place with relevant people in attendance.

We found the daily records staff made about the care and support they provided were linked to people’s care support plans. Monthly record books were provided to staff; these prompted a range of daily entries such as support with personal care tasks, activities of daily living, use of community facilities, the provision of meals, monitoring of health needs and, contact with family and health and social care professionals. There was separate documentation to record how staff monitored specific care needs. In addition, there was a monthly review of the care support plan. This ensured staff kept them updated when the person’s needs changed.

Staff completed risk assessments when issues posed a risk for specific people. These included, the use of equipment such as bed rails, wheelchairs and hoists, risks associated with medical conditions such as epilepsy, and daily support tasks such as bathing, eating and drinking and meal preparation. In addition, risk assessments were completed when people accessed community facilities such as swimming.

We saw people had personalised support plans to help them access community facilities and to participate in activities and occupations. These included, bowling, swimming, shopping, trips to the cinema and pubs, choosing holidays and having meals out. Two people attended a chair-based exercise class and one person attended a drama club each week. Two people accessed a sensory room at a local facility twice a month. There were also in-house activities such as games, art and crafts, helping to prepare meals and one person had weekly massage therapy.

Good

Is the service responsive?

There was a complaints policy and procedure and staff were familiar with the actions to take if they received a complaint or concern. The policy and procedure was in easy read format to help the people who used the service to understand the contents.

Good

Is the service well-led?

Our findings

People who used the service and their relatives knew the registered manager and deputy manager by their first names. We observed how people who used the service approached the registered manager and their responses to them. It was clear the registered manager knew people's needs well and had positive and caring relationships with them.

There was a clear hierarchy within the organisation, overseen by a Board of Governors, which consisted of a Chief Executive Officer, Directors, Regional Managers, Locality Managers, Assistant Locality Managers and Support Workers. The Locality Manager was also the registered manager for 8 Queens View Crescent and two other services in close proximity.

We spoke about the culture of the organisation with the registered manager and members of staff. They said, "It's an open culture; people can say what they think and what you say is taken on board", "I have to enable staff to use their skills and to enable them to feel they have knowledge and skills to make decisions" and "It's nice working here; we have a relaxed atmosphere and a good team. You can raise concerns and they will be dealt with." In the provider information return (PIR) received prior to the inspection, the registered manager told us staff were encouraged to come forward and report any mistakes they made so there could be learning from them. We found this happened in practice as we received notifications in a timely way of incidents that affected the health and wellbeing of people who used the service. We found the registered manager was aware of their role and responsibilities.

We found the organisation encouraged good practice. For example, there was a system in the organisation to nominate staff for specific awards for recognition of good practice. The organisation also had 'Investors in People', which was an accreditation scheme that focussed on the registered provider's commitment to good business and people management. Staff were provided with handbooks which explained what the expectations were of their practice. It also described the organisations vision. This was described as promoting an 'inclusive society where people have equal chances to live the life they choose'. The mission was to 'make a difference to people by delivering personalised support that improves the quality of life'. Staff received remuneration for long service within the organisation.

We saw staff had a one page profile completed, which highlighted their skills, interests and hobbies. These were completed to help the process of matching staff for key worker roles with the people they supported. The registered manager told us it was important this took place as it helped relationships to develop when there were common interests between staff and people who used the service.

There was a system in place to monitor the quality of service people received. This included audits completed in house by the registered manager and other members of the team, meetings and surveys to obtain the views of people who used the service and their relatives, and observations of staff practices.

Internal audits included checking care files, how finances were managed, stock checks of medicines, hand hygiene assessments, the environment and analysing incidents. There were also audits completed by the organisations 'compliance team'. The registered manager told us these could be up to four times a year and timings depended on risks that had been identified in previous audits completed by the team or self assessments by the registered manager. We looked at the audit record for January 2015, which covered areas such as involving people who used the service, management issues, checks of finances and medicines, health and safety, and records management. This showed us the auditor observed staff interactions with people who used the service, which included preparing lunch, putting shopping away, supporting with laundry tasks, supporting people to make choices and supporting a person to eat their lunch. It also demonstrated action plans were produced to address issues that had been identified as requiring improvement.

The registered manager undertook performance monitoring, during one to one sessions and annual appraisals with members of staff. The documentation used to record discussions had space to indicate whether mandatory training was up to date, any actions were required for staff attendance at work, key information was in place, annual leave had been planned appropriately and a consideration of equality and diversity issues. The registered manager stated that it was important staff

Good

Is the service well-led?

worked within the organisation's code of conduct and were respectful of each other and the people they supported. There were return to work interviews following sickness absences and procedures to deal with disciplinary issues.

We saw team meetings and handover meetings took place between staff to exchange information and to make sure they were kept informed. There were 'house meetings' where staff and people who used the service discussed any concerns and made plans regarding meals, activities and trips out. The records of 'house meetings' were in easy read format to improve accessibility for people.