Dimensions (UK) Limited

Dimensions 7 Huntley Close

Inspection report

7 Huntley Close
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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

This was an unannounced inspection that took place on 15 July 2016.

Dimensions 7 Huntley Close is a care home which provides accommodation and personal care for up to six people who have different forms of learning disabilities such as Autism whilst living with other complex needs such as epilepsy or cerebral palsy. At the time of our inspection there were five people living at the home. All of the accommodation is provided on the ground floor so that all facilities are accessible to everyone. There was a spacious and secure garden for people to use.

The home did not have a registered manager in place. 'A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 provider had arranged temporary management coverage at the home. We have been informed the provider has submitted application to the CQC to become the registered manager.

People and their relatives told us they felt safe at Dimensions 7 Huntley Close. Staff had a clear understanding about the signs of abuse and were aware of what to do if they suspected abuse was taking place. There were systems and processes in place to protect people from harm.

There were sufficient numbers of staff deployed who had the necessary skills and knowledge to meet people's needs. Recruitment practices were safe and relevant checks had been completed before staff started work.

Medicines were managed, stored and disposed of safely. Medicines were administered by competent staff and any changes to people's medicines were prescribed by the person's GP.

People lived in a safe well maintained environment. Fire safety arrangements and risk assessments for the environment were in place. The service had a contingency plan that identified how the home would function in the event of an unforeseeable emergency such as fire, adverse weather conditions, flooding or power cuts.

Staff were up to date with current guidance to support people to make decisions. Staff had a clear understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and as well as their responsibilities in respect of this.

The provider ensured staff had the skills and experience which were necessary to carry out their role. Staff had received appropriate support that promoted their development. The staff team were knowledgeable about people's care needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk; such as monitoring people's food and fluid intake and weight.

People had access to healthcare professionals who had specialist experience with people who had specific needs to support their well-being. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment.

Staff treated people with compassion, kindness, dignity and respect. People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's privacy and dignity were respected and promoted when personal care was undertaken.

People's needs were assessed when they entered the home and on a continuous basis to reflect changes in their needs. Staff understood the importance of promoting independence and choice. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People had the right to refuse care and support and this information was recorded in their care plans.

People were encouraged to voice their concerns or complaints about the service and there were different ways for their voice to be heard. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service people received.

People had access to activities that were important and relevant to them. There were a range of activities available within and outside of the home.

People's care and welfare was monitored regularly to ensure their needs were met. The provider had systems in place to regularly assess and monitor the quality of the care provided.

People told us the staff were friendly and management were always approachable. Staff were encouraged to contribute to the improvement of the home. Staff told us they would report any concerns to their manager and felt supported by the management.

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 had risk assessments based on their individual care and support needs.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

Recruitment practices were safe and relevant checks had been completed before staff commenced work.

There were sufficient numbers of staff deployed to keep people safe and to respond to their needs.

Medicines were administered, stored and disposed of safely.

Is the service effective?

Good

The service was effective.

People's care and support promoted their well-being in accordance to their needs. People were supported to have access to healthcare services and professionals were involved in the regular monitoring of their health.

Staff understood and knew how to apply legislation that supported people to consent to care and treatment.

People were supported by staff who had the necessary skills and knowledge to meet their assessed needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service was caring.

Staff treated people with compassion, kindness, dignity and

respect. People's privacy were respected and promoted.

Staff were cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes. People's relatives and friends were able to visit when they wished.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed when they entered the home and on a continuous basis. Information regarding people's treatment, care and support was reviewed regularly.

People had access to activities that were important and relevant to them. People were protected from social isolation and there were a range of activities available within the home and community.

People were encouraged to voice their concerns or complaints about the home. Suggestions, concerns and complaints were used as an opportunity to learn and improve the service people received.

Is the service well-led?

Good

The service was well- led.

The provider actively sought, encouraged and supported people's and staffs involvement in the improvement of the service.

People told us the staff were friendly, supportive and management were always visible and approachable.

The provider had systems in place to regularly assess and monitor the quality of care and support people received.

Dimensions 7 Huntley Close

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.

We visited the home on 15 July 2016 and it was an unannounced inspection. The inspection was conducted by one inspector so that we did not cause any unnecessary anxiety to people who lived there.

Prior to the inspection we reviewed the Provider Information Record (PIR) and previous CQC inspection reports. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make.

We gathered information about the home by contacting the local authority safeguarding and quality assurance team. The local authority and safeguarding team did not identify any concerns about the home. We also reviewed records we held which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the home is required to send us by law.

During the inspection we spoke to one person living at the home, one member of staff, the provider's locality manager and assistant locality manager. We observed care and support in communal areas and looked at two bedrooms with the agreement of the relevant person. We looked at records relating to people and the home such as three care records, one staff file, medicines records, training information, policies and procedures and other documentation relevant to the management of the home. After the inspection, we spoke to one relative to get their views on the care and support provided.

We last inspected the service on 1 September 2014 where no concerns were identified.

Good

Is the service safe?

Our findings

People were safe and were provided with guidance in easy to read picture format about what to do if they suspected abuse was taking place. A person told us, "Am ok here." A relative told us, "My [family member] is safe and so is the home as it is on one level, there is no risk of harm to them."

Staff were clear about their role in safeguarding and the systems in place to protect people. A member of staff told us, "I would report it to the manager [meaning the assistant locality manager]. The manager would take action and investigate the facts. The incident would be recorded. I know it has to go to our operations director as well as social services safeguarding team." The home had the local authority multi-agency safeguarding policy as well as current company policies on safeguarding adults. This provided staff with guidance about what to do in the event of suspected abuse. Staff confirmed that they had received safeguarding training within the last year.

The provider had systems in place to reduce the risk of financial abuse. There were arrangements in place to safely store people's money. We saw each person had their income and expenditure recorded and verified by the assistant locality manager. All monies were kept secure, in a locked room.

Risks to people were managed safely and in accordance with their needs. Personalised assessments identified a variety of risks and gave detailed information to staff on how to manage these. These included where people were at risk of injuries, falls, or by exhibiting behaviour that challenged. Risk assessments and healthcare issues that arose as a result were discussed with the involvement of social or health care professionals such as an occupational therapist, incontinence team, or district nurse. One person had mobility issues and moved in a certain way that left them at risk of pressure sores and injuries. A plan was in place to protect them as well as providing them with specialist equipment to use to protect them from injuries. The risk assessments were in line with the provider's policy of, 'Never events'. This contained guidance on what should be in place to prevent the events from occurring, for example, no one with epilepsy had a bath unsupervised.

People were supported to be kept safe because there was a system to manage and report incidents and accidents and action was taken to prevent reoccurrence. Staff told us they would report any concerns to the assistant locality manager and were confident they would be acted upon. Each accident had an accident form completed, which included action taken. For example, where a person had been injured, treatment had been recorded along with a body map indicting where the wound had occurred. Information was also sent to people who were involved in people's care such as their Care Manager or relative. Incidents were reviewed and monitored to identify patterns or trends emerging, which enabled staff to take action to minimise or prevent further incidents occurring in the future.

People lived in a safe well maintained environment. The communal areas and corridors were free from obstacles and handrails were placed throughout the home to support and aid people's mobility. People had access to bathrooms that had been adapted to meet their needs; there was specialist equipment such as large cushioned mats, bed and chair raisers, adjustable chairs and specialist beds as required. Fire,

electrical, safety and specialist equipment were inspected on a regular basis to ensure they were safe and in working order. Arrangements were in place for the security of the home and people who lived there. Entry to the home was managed by staff. A book recorded all visitors to the home.

Arrangements were in place to minimise the impact on the delivery of care during an emergency. Fire safety arrangements and risk assessments for the environment were in place. Each person had a personalised emergency evacuation plan, staff carried out regular fire drills and evacuations so they knew what to do in the event of a fire. There was a contingency plan in place and staff had a clear understanding of what to do in the event of an emergency such as adverse weather conditions, power cuts or flooding.

There were sufficient numbers of staff deployed to meet people's needs safely. The core staff team had been working at the home for a long time and had built up a rapport with people who lived there. The assistant locality manager confirmed that they would only use agency staff as a last resort and would require the same agency member of staff to attend throughout to ensure consistency and reduce the disruption to the home. The staffing numbers were based on the individual needs of people. This included supporting people to attend appointments, external activities or accompanying people on holiday. Staff attended promptly to assist people when they requested it and we saw staff had time to chat to people.

People were protected from being cared for by unsuitable staff because there were robust recruitment processes in place which had been followed. All applicants completed an application form which recorded their employment and training history. We saw from the records that staff were not allowed to commence employment until satisfactory Disclosure and Barring Service (DBS) checks and references had been received. A DBS identifies if a person has a criminal record.

People had their medicines on time and as prescribed. Only staff who had attended training in the safe management of medicines were authorised to give medicines. We saw staff administer medicines to one person; they explained the medicine and waited patiently until the person had taken it. Any changes to people's medicines including home remedies (medicines that can be bought over the counter) were prescribed by the person's GP.

Arrangements were in place to record and store medicines. The medicines administration records (MAR) were accurate and contained no gaps or errors. A medicines profile had been completed for each person and any allergies to medicines recorded so that staff knew which medicines people could safely receive and which to avoid. A photograph of each person was present to ensure that staff were giving medicines to the correct person. There was guidance for people who were on PRN (as needed) medicines. PRN records included dosage details of these medicines and the reason they may require them. All medicines coming into and out of the home were recorded and medicines were checked and recorded at each handover.

Good

Is the service effective?

Our findings

People were supported by competent staff who provided individualised care and support to promote a good quality of life. A relative told us, "[Family member] is quite settled at the home. She knows her own routine, as do staff and they know what she likes and dislikes."

There were sufficient qualified, skilled and experienced staff to meet people's needs. The provider ensured staff had the skills and experience which were necessary to carry out their responsibilities through regular training and supervision. New staff confirmed that they attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. Where additional duties were covered by staff from other local homes managed by the provider, the assistant locality manager ensured they had the same training and had the skills and knowledge needed to meet people's needs.

Staff confirmed they had received training and that they had sufficient knowledge to enable them to carry out their role safely and effectively. The provider's records confirmed that all staff had received mandatory training such as; epilepsy; positive behavioural support, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Training was delivered in different formats such as online learning, DVDs and face to face training courses.

Staff had received appropriate support that promoted their professional development. Staff confirmed they had regular meetings with their line manager to discuss their work and performance. A member of staff told us, "Yes it is very useful catching up and knowing where you are in terms of your performance." Documentation confirmed that regular supervision and annual appraisals took place with staff. Management observed staff in practice to review the quality of care delivered and any observations were discussed with staff with the aim of improving the care they offered to people.

Staff demonstrated they knew people well. They explained strategies on how to approach people during our visit to ensure we did not cause them anxiety. We read information recorded in people's care plans that corroborated what staff had told us.

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.

Where people did not have the capacity to make a specific decision and their best interests had been considered staff had followed the legal requirements. Assessments had been completed where people were unable to make specific decisions such as refusal of dental treatment. This included information regarding people's authority to make decisions on people's behalf such as Power of Attorney or Deputyship.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards, (DoLS)

which applies to care homes. 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 and in their best interests. We saw that the previous registered manager had completed and submitted DoLS applications in line with current legislation to the local authority. Applications related to people being accompanied out in the community and those who required restricted access to the front door. A relative told us, "[Family member's] freedom is restricted as they are vulnerable when they go into the community. [Family member] also goes on holiday but needs to be accompanied by staff."

People were supported to make their own decisions and their consent was sought before care was provided. Staff checked with people that they were happy with the support being provided on a regular basis and attempted to gain people's consent. Staff waited for a response before acting on people's wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. Where people declined assistance or choices offered, staff respected these decisions.

A relative told us about the food at the home. They said, "We don't have any problems with the food at the home. They know what she likes to eat." Staff prepared and cooked all of the meals and people were involved in the choice of menu for breakfast, lunch and tea. The menu was in a pictorial format that people could easily understand. There was a choice of nutritious food, drinks and snacks and an alternative option was available if people did not like what was on offer. People who were able to eat independently were prompted and encouraged to do so and specialist cutlery was available for people to use. Throughout the meal we observed staff interacting with people and asking them about the food. People were encouraged to take regular drinks, to ensure that they kept hydrated.

People had their dietary needs assessed and specific care records had been developed in relation to this. We observed people were provided with well-presented pureed meals, in accordance with their care plan, to reduce the risks of choking. Where people needed assistance with eating or had special dietary requirements, information and guidelines were recorded to ensure their needs were met. Some people required products to be added to their food and drink to enable them to swallow without harm and instructions were given to staff regarding the dosage and consistency required.

We saw that food and fluid charts were completed for people who needed their nutritional intake monitored. Staff had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. Staff confirmed that a dietician or the speech and language therapy team were involved with people who had special dietary requirements. People's weight was monitored and recorded on a monthly basis.

People had access to healthcare professionals who had specialist experience and knowledge to support their well-being such as the GP, dentist and psychiatrist. People were supported by staff or relatives to attend their health appointments. One person was scared of the dentist and guidelines were in place for the dentist (where possible) to see the person in the home's mini bus as they knew they would not come into the surgery as this would trigger their anxiety.

People had access to a learning disability nurse at a local hospital, who liaised with people to ensure they had a smooth transition should they require admission to hospital. If people's needs changed staff obtained guidance or advice from the person's doctor or other healthcare professionals. Outcomes of people's visits to healthcare professionals were recorded in their care records. Staff were given clear guidance from healthcare professionals and what they needed to do to support them and staff followed this guidance. A

relative told us, "There are well-established guidelines with [family member] and staff follow them."

People's bedrooms were personalised with art work, photographs and items of religious sentiment and personal interest. Each room had a photograph of the person whose room it was on the door so their room was easily identifiable to themselves and others. People were able to choose the colour and furnishings for their room. The floorings throughout the communal areas enabled people with wheelchairs or mobility issues to easily manoeuvre around the home. Communal areas such as toilets and shower rooms had signs to describe the room.

Good

Is the service caring?

Our findings

The atmosphere in the home was calm and relaxed during our inspection. Staff showed kindness to people and interacted with them in a positive and proactive way. People were happy and laughing whilst enjoying being in the company of staff. A relative told us, "[Staff member] knows [family member] well and interacts with [family member]. They both are the same age and are well suited."

People were shown empathetic care by staff. One person became extremely upset during our visit. Staff made sure they were reassured, checked to see if they were in pain, made them a drink and took them in the lounge to calm them down. Another person was upset by the death of a person who had lived at the home. Staff had created a bereavement book which enabled them to have positive memories of the person and discuss their feelings.

Staff understood the importance of choice. People were able to make choices about their care and support, such as when to get up in the morning, what to eat, what to wear and activities they would like to participate in and help maintain some independence. People had the right to refuse treatment or care and this information was recorded in their care plans. For example, when people refused dental treatment.

People were supported by staff that knew them. People were allocated a member of staff known as a key worker. A keyworker has responsibility for making sure a person receives the care and support that is right for them and communicates this to the rest of the staff team. Staff told us the keyworker system worked well as staff were able to support people whom they shared common interests with, had specialist experience of or training to meet their specific needs. Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. Information was recorded in people's care plans about the way they would like to be spoken to and how they would react to questions or situations. For example, 'if I am in pain, I will cry and point', 'if I am laughing it means I am happy'. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them. Care records were reviewed on a regular basis or when care needs changed.

Staff approached people with kindness and compassion. Throughout our visit we observed good caring practice between people and staff. Staff always spoke to the person when supporting them; this was done in a respectful and friendly manner.

Staff called people by their preferred names and staff interacted with people throughout the day. Staff checked that people were happy at each stage when participating in activities, listening to music and watching television.

Privacy and dignity was respected and people received care and support in the way they wished. Staff understood the importance of respecting people's privacy and dignity and treating people with respect. Staff were seen to discreetly advise people when they required attention to their personal care and this was always provided in private. A member of staff told us, "We genuinely care about them and want the best for them."

People and relatives were involved in the discussion about their family member's care, support needs and end of life care. Documentation was provided in easy to read pictorial format so that people were able to understand and be involved in the decision making process. We observed that when staff asked people questions, they were given time to respond. Relatives, health and social care professionals were involved in individual's care planning.

Relatives and friends were encouraged to visit and maintain relationships with people. Staff supported people to visit their relative's homes. Each person had detailed information about people who were important in their lives. People were protected from social isolation with the activities, interests and hobbies they were involved with. They were also encouraged through various social events to develop friendships with people living at other homes owned by the provider.

Good

Is the service responsive?

Our findings

People told us they were happy with the support they received. A relative told us, "They are very good at letting me know if they have any concerns about my [family member]'s well-being. We will discuss what is best for [family member]."

Pre-assessments were carried out before people moved into the home to ensure people's needs could be met. These were reviewed once the person had settled in. The information recorded included people's personal details, care needs, and details of health and social care professionals involved in supporting the person. Other information about people's medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were also recorded. Information was used to develop care and support in accordance to people's needs.

People had their needs assessed and staff responded to those needs. Specific care plans had been developed in relation to this. For example, where people had specific dietary needs relating to their condition, or required equipment to assist with their care. One person walked on their knees which had caused abscesses. Following a referral to the occupational therapist the person now wore specialist shoes and had a trolley to aid with their mobility which had reduced the risk of them developing further sores.

People's care plans contained important information about their care and support should they require hospitalisation. This enabled hospital staff to know important things about people, such as their medicines, allergies, medical history, mental and physical needs and how to keep them safe during their stay in hospital.
Changes to people's care was updated in their care record which helped ensured that staff had the most up to date information. Staff told us they completed a handover session at the beginning of each shift which gave them the opportunity to share information about any changes to people's needs. Daily records were completed to record each person's daily activities, personal care given, what went well, what did not and any action taken.

People confirmed that they took part and enjoyed the activities within and outside of the home. Including dancing, baking, art, listening to music and trips. We saw photographs of outings or events people had attended. Staff encouraged people to engage in activities and plan holidays. They offered a variety that catered to people's needs and interests such as aromatherapy sessions and cinema trips. The range of activities meant that people were less likely to experience social isolation.

There was a complaints policy in place. Staff had a clear understanding of what to do if someone approached them with a concern or complaint and had confidence that the assistant locality manager would take any complaint seriously. We reviewed the complaints log and noted there were no complaints about the home in the last twelve months. The assistant locality manager told us that when people had any concerns they tried to resolve the situation before it escalated. A relative told us, "I have never had a make a compliant."

Good

Is the service well-led?

Our findings

People spoke positively about the home. One person gave us a thumbs up and smiled which indicated they were happy when asked about the home. A relative told us what was good. They said, "It is small and it operates like a family. They have a mini bus which enables people to get out and about and they make sure special things are celebrated like birthdays."

People were involved in how the home was run. Peoples' feedback was sought in a variety of ways such as meetings, discussions with people and their relatives. There were 'Family Forum' meetings for people to provide feedback about the home. We read minutes of the last meeting which included updates from the provider on a regional and local basis. For example, the bathroom was being refurbished into a wet room to cater for the changing needs of the people living at the home. People were involved in the recruitment process and as part of this process prospective applicants were invited to the home is see how they interacted with people.
At the time of our inspection, the service did not have a registered manager which is a condition of registration with the Care Quality Commission (CQC). We were informed following the inspection that the provider had submitted an application to be registered as manager with the CQC).

We saw that the assistant locality manager had an open door policy, and actively encouraged people to voice any concerns. They engaged with people and had a vast amount of knowledge about the people living at the home. They were polite, caring towards them and encouraging them. People felt she was approachable and would discuss issues with them.

Staff had the opportunity to help the home improve and to ensure they were meeting people's needs. Staff were able to contribute through a variety of methods such as staff meetings and supervisions. Staff told us that they were able to discuss the home and quality of care provided, best practices and people's care needs. For example, a member of staff told us, "We get regular updates from [person]'s family about their condition which helps me to inform staff how best to approach [person] and how to work with her as I know her and her needs." Staff felt valued and they told us that the assistant locality manager was approachable and available.

The provider had a system to manage and report incidents, accidents and safeguarding concerns. Incidents and safeguarding concerns had been raised and dealt with and relevant notifications had been received by the CQC in a timely manner. The senior management team reviewed each incident form and commented on the action taken or any further action required that was recorded.

People's care and welfare was monitored regularly to make sure their needs were met within a safe environment. There were a number of systems in place to make sure the staff assessed and monitored the delivery of care. Various audits were carried out such as health and safety, room maintenance, housekeeping, care plans. Any issues were identified and action plans put in place to rectify the concerns raised. For example, a fire drill conducted in July 2016 took four minutes to complete. The assistant locality manager identified that this had taken too long and the matter would be addressed at the next team

meeting. Staff told us they conducted a weekly spot check on rooms to check on the condition of the room in relation to health and safety needs.

We looked at a number of policies and procedures relating to the environmental, complaints, consent, disciplinary, quality assurance, safeguarding and whistleblowing. The policies and procedures gave guidance to staff in a number of key areas. Staff demonstrated their knowledge regarding these policies and procedures. This provided staff with guidance to enable them to provide safe and effective care.