Dimensions (UK) Limited

Dimensions Woodmere Lower Wokingham Road

Inspection report

Woodmere
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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 which took place on 24 May 2016.

Dimensions Woodmere is a residential care home which provides a service for people with learning and other disabilities, such as people on the autism spectrum. The service is registered to provide care for up to six people. There were six people living there on the day of the visit. People were provided with shared or single, self-contained flats. There were two shared and two single flats with communal facilities such as the garden and the laundry.

There is a registered manager running the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe from any form of abuse because staff were properly trained so they knew how to protect people. The service took people's, staff's and visitors' health and safety seriously. Policies and procedures which staff understood were followed to keep people as safe as possible. Any risks were identified and action was taken to reduce them. There were high staff ratios to ensure people were looked after safely. The recruitment procedures were robust and made sure, that as far as possible, staff were safe and suitable to work with the people who live in the home. Medicines were given safely by properly trained staff.

People were supported to stay as healthy and happy as possible. The staff team sought advice from and worked closely with health and other professionals to meet people's needs in the best way. People's emotional needs were met to ensure people were able to enjoy their lives as much as they could.

Peoples' rights were protected by the staff and registered manager of the service. The service understood how the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who may not have capacity to do so. People were helped to make decisions and choices so they could control as much of their daily lives as possible. People were encouraged to be involved in all aspects of the running of their home.

People were provided with care by a staff team who knew them well and who understood their individual needs. Staff were well trained, understanding and responsive to changes in people's needs and wishes. People were treated with respect, kindness and dignity at all times. Staff understood what person centred (individualised) care meant and why it was important. They were non-discriminatory and met people's equality and diversity needs. People were provided with a variety of activities, according to their needs, abilities and preferences.

The service was well-led by a respected registered manager and supportive management team. The service had a positive culture and open management style which encouraged people, staff and others to express their views and opinions. The quality of the care provided was maintained and enhanced as appropriate.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood how to protect people in their care. They had been properly trained so they knew what to do if they identified any form of abuse.

Risks to people's safety were identified and any necessary action was taken to make sure they were reduced, to keep people and others as safe as possible.

Staff were trained to look after and give people their medicines safely.

There were enough staff, who had been recruited safely, to meet people's needs and keep them safe.

Is the service effective?

Good

The service was effective.

If people could not make certain decisions, staff made sure their rights were upheld and they did what was best for them.

People were encouraged and supported to make as many choices and decisions about their daily lives, as they could.

Staff helped people to stay as happy and healthy as possible.

Staff were well trained to meet the needs of the people in their care.

Is the service caring?

Good

The service was caring.

Staff were kind and patient and knew people well.

People's privacy was respected and they were helped to maintain their dignity, at all times.

People were treated as individuals and their preferences and

lifestyle choices were respected.

Staff built strong relationships and trust with people and their families.

Is the service responsive?

Good

The service was responsive

Staff met people's current needs.

Staff helped people to keep their relationships with families and others who were important to them.

People were able to choose to do a variety of activities they liked so that they enjoyed their lives, as much as possible.

People, their families and others knew how to and could make complaints about the service, if they wanted or needed to.

Is the service well-led?

Good

The service was well-led.

The service was well-managed. The registered manager knew all about the needs of the people who live there and helped her staff to give people good care.

People, staff and others involved with the service were listened to and their ideas and views were acted upon, if possible.

The quality of care the service was providing was looked at by the registered manager and others and things were made better for people, if possible.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and took place on 24 May 2016. It was completed by one inspector.

Before the inspection the provider sent us an information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at six care plans, daily notes and other documentation, such as medication records, relating to people who use the service. In addition we looked at other records related to the running of the service. These included a sample of health and safety, quality assurance and training records. The registered manager sent us further information we requested after the inspection visit.

We spoke with four people who live in the home, three staff members, the registered manager and assistant manager. We asked for comments from eight local authority and other professionals and received two responses. We looked at information held about the six people who live in the service and observed the care people were offered throughout the duration of our visit.

Good

Is the service safe?

Our findings

People told us or communicated in the way described on their plans of care that they felt safe in the home and with the staff. When asked if they felt safe they smiled, answered yes or nodded. Some people 'touched' staff and smiled. Staff told us they were, "absolutely sure the manager would take immediate action if we had any worries about people's safety." A professional commented, "The staff are always accommodating when issues arise and I have no concerns over the safety and wellbeing of the customers."

People were kept as safe as possible by a staff team who received regular training in safeguarding vulnerable adults. Staff were fully aware of their responsibilities with regard to protecting people in their care. They were able to describe how they would recognise and deal with a safeguarding concern or incident. The service had not reported any safeguarding concerns during the preceding 12 months. Staff were fully aware of the provider's whistle blowing policy and told us they would not hesitate to use it. However, they told us they were confident they would not need to as the manager would not tolerate any form of abuse or poor care. Contact details of people who could be approached, outside of the organisation were prominently displayed on the walls of staff areas.

Staff followed the service's health and safety policies and procedures to keep people, themselves and visitors to the service, as safe as possible. The service had an appointed health and safety representative who met with those from other services, every three months, to discuss any health and safety issues. For example any problems identified or any new legislation relating to social care. They passed any relevant information back to the staff team. Additionally they took the responsibility to ensure health and safety checks and maintenance schedules were completed, as required. Checks included water safety and legionella testing every three months (last one April 2016), fire equipment tests and safer food audits. The service was awarded a five star (very good) rating, for food hygiene, by the environmental health department in July 2015.

The service had completed a health and safety risk analysis and put in place necessary risk assessments. These included chemical safety, lone working and infection control. All health and safety risk assessments were up-dated in April 2016. The service had developed an emergency planning pack which was located in the 'on call' folder for easy access. It included emergency contact numbers, individual's medicines information and the fire plan and emergency procedures. People had individual emergency evacuation plans.

People had an individual risk analysis to identify any risks specific to them. Risks were identified, assessed and methods of reducing them were added to people's individual support plans. They detailed how to support the person in a way which minimised the risks to them, the staff and others. Risks identified included choking, bathing, health and use of the kitchen.

Accidents and incidents were recorded and records included the action taken to reduce the risk of recurrence. Accidents and incidents were cross referenced to risk assessments and care plans. An example included an unexplained bruise which may have occurred in the community. It had been investigated,

although no cause was found. Action taken was to check people, if appropriate, before they left the service and discussion about whether to make use of body maps.

Staff were properly trained to give people their medicine safely, as prescribed by the GP. Their competency to administer medicines was tested before they were allowed to carry out this duty. No medication administration errors had been reported in the previous 12 months. The service used a monitored dosage system (MDS) to assist them to administer medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MARs) were accurate and showed that people had received the correct amount of medicine at the right times. People had detailed guidelines for the use of any PRN (to be taken as necessary) medicines. A pharmacist had visited the service on 5 April 2016. They had made a small number of minor recommendations, recorded the service had complied with those from the last visit and noted that no follow up visit was necessary.

People's finances were looked after safely, each person had a financial file and financial care plan. The local authority acted on behalf of the Court of Protection to oversee the finances of all six people. The service kept personal monies in the house for people to access and requested money for any large expenditure. The local authority audited people's money, held by the service, every six months.

Staff were suitable and safe to work with people. The provider's recruitment processes made sure that the necessary safety checks on prospective applicants were completed prior to appointment. These included Disclosure and Barring Service (DBS) checks to confirm that employees did not have a criminal conviction that prevented them from working with vulnerable adults. Application forms including full work histories were completed and interviews were held. Appropriate references were taken up and verified prior to candidates being offered a post.

There were enough staff on duty to enable them to assist people, in their individual flats. The minimum numbers of staff on duty were four per shift during the day (7.30am until 3 pm and 2.30pm until 10 pm). There was one waking night staff and one staff member sleeping in. The number of staff was calculated by assessing the care needs of each person, the amount of care hours individuals needed and providing those hours. Any shortfalls of staff were covered by staff working extra hours, agency staff or the management working on the care rota. Only agency staff who knew people were used, as far as possible. The registered manager could increase the number of staff in the event of special activities such as holidays or crises such as hospital admissions.

Good

Is the service effective?

Our findings

People's health and well-being needs were identified and met by a knowledgeable and well trained staff team. People had a detailed health care plan which included paperwork to be taken to hospital. This contained information the hospital staff would need to provide appropriate care for the individual. Health care records included all contacts with health and well-being professionals, follow up appointments and further actions to be taken. A professional told us, "They will ask for write ups from the visit to ensure that information given has been recorded, understood and shared. Reports and guidelines have been observed to be referred to and adhered to."

Appropriate referrals were made to other health and well-being professionals such as dieticians, speech and language therapists, healthcare consultants and nurses from the community learning disability teams. People were supported to attend specialist appointments and regular check-ups such as annual health reviews, dentists and opticians appointments. The registered manager told us they had an excellent relationship with the GP who had established very positive relationships with individuals and the staff team.

People had plans of care which ensured staff knew how to meet people's identified needs. The support plans included a summary of the important aspects of people's care. These described, more briefly, people's needs and gave staff quick and easy access to important information about individuals. These were invaluable as care plans were provided in five files per person and included some repetitious information. However, the care plans included all necessary cross- referencing and provided extremely detailed information about all aspects of the individual's care.

Staff helped people to make as many decisions and choices as they could. They described how they supported people to make decisions by using pictures and items as points of reference so that people who could not verbalise their choices could indicate what they wanted. People's individual communication methods were identified and understood and staff were able to interpret their wishes. Care plans included a support agreement which was produced in an easy read format. They recorded how the agreement had been explained to people and how people had given/shown they consented to it. People were provided with informal and formal (independent mental capacity advocate) external advocates as required.

People's rights under the Mental Capacity Act 2005 (MCA) were fully understood by the management and staff team. 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 the least restrictive option.

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 procedures for this in care homes and hospitals are called Deprivation of Liberties Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive people of their liberty were being met. The registered manager had made six DoLS referrals which had been

authorised by the local authority (the supervisory body). Applications for up-dated DoLS authorisations were made, according to the legal requirements.

All staff had received Mental Capacity Act 2005 and DoLS training. They were able to explain what a deprivation of liberty was and the action they would take if they were concerned that they had to deprive someone of their liberty. Decisions were only made in people's best interests and meetings were held to show that decisions about issues such as health interventions and hair cutting had been taken by the appropriate people.

The staff team supported people to control any behaviour that could cause distress or harm to themselves or others. Behaviour plans were developed, as necessary, with the help of community teams for people with learning disabilities. Behaviour support plans focussed on staff responding to the early signs of agitation and taking action to distract and divert people from displaying any harmful or distressing behaviour. Physical intervention was not used in the service.

People were offered good quality food which met their identified individual needs. Nutritional needs were assessed and any specific requirements were included in their care plans. The support of the dietician and speech and language therapy services was sought, as required. People ate in their own flats or with friends, as they chose. Meals were provided in a variety of ways, such as soft food or food cut into small pieces, to meet the needs of individuals. Risk assessments were developed, if necessary to ensure people were given food as safely as possible. People chose their menus every week but were able to have alternatives, if requested.

People were provided with any equipment to ensure their comfort, safety and mobility. For example one flat had an adapted bath fitted so that people with poor mobility could us it safely. Double handrails were fitted to stair cases and wheelchairs were supplied, as necessary. The assistance of occupational therapists was sought if a mobility or safety issue was identified.

People's diverse and changing needs were met by a staff team who received appropriate and effective training. Training was delivered by a number of methods which included computer based and classroom learning. Staff told us training was, "excellent." One staff member said," we can ask for any additional training we think we need." Of the 11 staff nine had completed a relevant social care or health qualification. The service used a computer system to record and up-date training and the management team audited records to ensure people received 'core' training in a timely manner. A professional commented, "I have recommended staff training around a specific issue and this was followed up and provided by myself. I found the staff team to engage with the training and took on board the items discussed."

Staff received one to one supervision approximately every two months and an appraisal once a year. Staff told us they were very well supported by the registered manager and their colleagues.

New staff told us they received a very good induction which equipped them to work safely with people. They said they were not pressured into completing tasks until they felt competent and confident to do so. The service used the care certificate framework (which is a set of 15 standards that new health and social care workers need to complete during their induction period) as their induction tool. The service operated a six month probationary period and ensured staff were performing well and had the right attitudes before they were given a permanent contract.

Good

Is the service caring?

Our findings

People told us verbally or indicated by smiling broadly, that they liked living in the service. People were supported by care staff who were committed to their well-being and were kind and patient. We saw that staff explained to people what they were doing and why and asked for their permission before they undertook any task. Staff interacted positively with people, They praised them for small achievements and used 'banter' and 'humour' as appropriate persuasion techniques. People responded to staff's gentle approach and joined in with the 'humour' to communicate their feelings. For example, one person gently 'teased' another which resulted in laughter and giggling from all concerned. A professional commented, "I have found staff to be respectful in their approach to people – both visitors and service users." Another said, "I have worked with the staff from Woodmere for many years and have always found them to be devoted to the care of the clients often going above and beyond what is expected."

People were as involved in the care planning and review process as they chose to be and their involvement was clearly recorded. With people's consent their families or others who could represent them were kept informed of how they were progressing or otherwise. Families and representatives were invited to reviews of care if people wanted them to be there and if it was appropriate. The service had a written 'family charter' which was included in individual's care plans. It told families and friends of people what they could expect from the service. It included, how the staff team would work with the family and how family and friends would be involved in their relative's care. It noted people's rights and explained the sharing of information would be as the person chose and consented.

The service used a variety of methods to find out what people thought about the care they were offered. For example, people met with their key worker once a month to discuss their views on the care they were being offered and the lifestyle they were pursuing.

Staff had developed a communication plan for people. This was especially detailed for people who were not able to verbally communicate. Communication plans described, in detail, how people made their feelings known and what behaviours and gestures meant. For example, if I giggle and pinch I am happy, if I push you away I am not happy. The plans also instructed staff how to communicate with people such as, using simple words, showing pictures and using any specific signs people understood. The plans helped staff and others to understand people and people to understand them. People and staff communicated positively with each other during the inspection visit. Additionally, people were encouraged to communicate with each other, which they did.

Any information that was relevant to people, such as, 'what Dimensions does about medication', the health action plan and the support agreement were produced in an easy read format. The easy read format consisted of pictures, symbols and simple English and some were designed specifically for the individual. This gave people the best chance to understand them.

Staff maintained and promoted people's privacy and dignity at all times. Staff received training in this area and were able to describe what action they took to make sure they respected people's privacy and dignity.

They also told us how they encouraged people to maintain their own. They gave an example of negotiating with health professionals so a person did not have to have checks during the night, which they found intrusive.

People's equality and diversity needs were met by staff who were trained in and knowledgeable about this topic. Care plans included any special needs people had to support their culture, religion or other lifestyle choices. For example, if people expressed a wish to receive same gender care, this was respected. People were provided with equipment to enable them to increase their mobility and opportunities to access the community.

People had end of life care plans in place. These explained people's wishes for if they became very ill and what they wanted to happen after their death. The staff showed compassion and understanding of the needs of people who had an illness that was potentially life threatening. We saw that they received additional support and assistance when it was required. People were accompanied to specialist consultations and staff advocated on their behalf. The possible consequences of the illness were explained in a way that did not distress people or cause them too much anxiety.

Good

Is the service responsive?

Our findings

The staff team were very responsive to people. They responded to requests for help or assistance, however it was expressed. Care staff were knowledgeable about people's needs and were able to interpret body language and other forms of communication to recognise when people needed assistance. A professional noted, "I have found the staff team very polite and professional in manner, engaging and always provide a warm welcome."

People's needs were assessed before they moved in to the service. They and their families, social workers and other services were involved in the assessment process, as appropriate. A care plan was developed from the assessment and agreed by the person or their representatives. A formal multi-disciplinary review of the care package was held once a year and if people's care needs changed. Care plans were reviewed approximately once a month by means of a monthly key worker meeting with the person and a review of the daily notes written during the month. Additional reviews took place if people's needs changed in the short or long term.

The service offered people very person centred care. Staff were trained to provide person centred care and described it as, "People making choices and keeping control of their everyday living. It's about us working around individual's wishes and needs. It's all about them not us." People's care plans were individualised and ensured that staff were given enough information to meet their specific needs. Care plans included sections called, 'my favourite routines', 'dreams for the future' and 'my gifts and skills'. The roles and responsibilities of the person and the staff members were recorded on care plans. The skills, training and personality traits staff needed to enable them to be 'matched' to an individual and offer the required support was noted and provided, whenever possible. However, people could choose to be supported by a particular member of staff who was on duty, on a daily basis. Staff responded to these choices and people were, generally, assisted by their chosen staff member.

People were offered a variety of activities and supported to participate in those they enjoyed. People's activity programmes were flexible and chosen, from a list of those available, on a daily basis. The service had found that this method was more effective than using a weekly activity planner. Staff were able to respond to people's different states of emotional well-being, physical well-being preferences and choices, every day. For example depending on people's emotional well-being they might choose to stay in the house to do craft work instead of going out into the community. One person had chosen to stay in on the day before the inspection and go on a train ride on the day of the visit. Activities included meals out, bowling and attending music groups or formal day services. People were given the opportunity to participate in outings and an annual holiday.

The registered manager and staff team had developed strong relationships with people's families, other professionals and anyone else who were important to them.

People, their families, friends or advocates were able to complain if they wanted to. The service's complaints policy and procedure was produced in an easy read format so that people had the best chance to

understand it. Staff were aware that some people were unable to make a formal complaint without assistance and were able to describe how people would let them know if they were not happy. The service had not recorded any complaints about the service during the previous 12 months.

Good

Is the service well-led?

Our findings

Staff described the registered manager and the management team as, ''Very approachable and very supportive." They told us that the registered manager makes them feel valued and an important part of the staff team. They described the team as, "Very strong." They said they and the registered manager were committed to giving people the best possible care. Staff described the culture of the service as open and positive. The registered manager held management and care qualifications. She was called a locality manager and registered to manage three homes with the assistance of an assistant locality manager. A professional commented, "I hold the manager in high regard, she always appears to have the residents best interest at heart. As an organisation Dimensions work hard to deliver good quality services and support their staff very well."

People knew the registered manager and the assistant locality manager and responded to their presence very positively. The managers knew people well and were fully aware of their individual needs. Staff told us that the registered manager visited frequently and was always available either in person, via e-mail or on the telephone. They felt well supported even though she had limited time available for each service.

People benefitted from a service which was monitored and assessed to make sure the quality of care offered was maintained and improved, as appropriate. There were a number of regular auditing and monitoring systems in place. Examples included medicines, incidents and accidents, people's finances and health and safety. A quality assurance audit (called a compliance audit) was completed every three months, by the provider's quality team. The service was rated from green to red (red being non-compliant) and any issues were included in a service action plan. Woodmere had never received a red rating from the provider. The management team completed unannounced, random 'spot' checks in the service to check staff performance and that staff were adhering to the values and principles described by the provider. These included respecting people and allowing people to determine their daily lives. We saw that staff adhered to these principles in their daily work. Additionally, staff appraisals included a ''360 degree'' review. For this review the supervisor sought the views of people who use the service, colleagues, people's families, and other professionals to ensure the quality of staff performance.

People's, staff's and others views were collected and listened to. The service had a number of ways of listening to people, staff and other interested parties. People had four to six weekly key worker meetings with staff to discuss their satisfaction with the service. The registered manager told us these 1:1 meetings were more effective in gaining people's views than the resident meetings that were held in the past. Care plans were reviewed regularly and people, their families, friends or advocates were asked for their views, which were recorded. Staff views and ideas were collected by means such as, regular team meetings, staff forums and 1:1 supervisions. Actions taken to improve people's experience included enhancing the garden, providing a more attractive environment and enabling people to gain more control of their daily lives. For example, people were able to choose who they wished to work with and what they wanted to do, on a daily basis.

People's needs were accurately reflected in detailed and up-to-date records. They informed staff how to

meet people's needs according to people's preferences, choices and best interests. Records relating to other aspects of the running of the home such as audit records and health and safety maintenance records were also accurate and up-to-date. The registered manager understood that statutory notifications had to be sent to the Care Quality Commission when required and in the correct timescales. Additionally, they kept up-to-date with regulation and legislation, such as the duty of candour responsibilities. There had been no notifiable incidents in the service during the preceding 12 months.