Dimensions (UK) Limited

Dimensions 43 Clayhill Road

Inspection report

43 Clayhill Road
Burghfield Common
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Date of inspection visit:
23 November 2017
24 November 2017

Date of publication:
24 January 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Dimensions 43, Clayhill Road is a residential care home for up to six people with a learning disability. Some people may also have needs within the autistic spectrum. The service has two floors and people's bedrooms were on both the ground and first floors.

At the last inspection, the service was rated Good, with Requires improvement (no breach) in Safe.

At this inspection we found the service remained Good and improvements had been made so that the service was also rated Good in Safe.

The service met all of the fundamental standards. People felt safe, well cared for and that they were treated with respect and dignity. We could see from people's body language and facial expressions that interactions with staff were relaxed, friendly and respectful. Long term positive relationships with staff had also contributed to a reduction in instances of challenging behaviour. Staff were caring and treated people with patience and kindness, involving them in their care as much as possible, enabling and encouraging choice.

People were safe because staff understood how to keep them safe and acted appropriately. Identified risks to people and from the environment or equipment were minimised through effective risk assessments and actions were taken to address them.

People received their medicines as prescribed because the service had an effective system to manage these on people's behalf.

A robust staff recruitment process helped ensure staff were suitably skilled and had the right caring approach to work with vulnerable adults. Staff received a detailed induction and thorough ongoing training They received ongoing support through one to one supervision, annual appraisals and periodic team meetings.

Staff communicated effectively about people's needs and it was hoped the new recording system being introduced would further enhance this and effective record keeping.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. Their legal rights and freedom were protected and their consent was sought before support was provided. People were involved in choosing their meals, shopping and preparation as much as they wished and received a varied and nutritious diet. Their healthcare needs were met effectively.

The provider had already carried out some adaptation to the premises to meet people's changing needs and was continually reviewing this to meet future needs. Equality and diversity needs were addressed appropriately and people were able to express their individuality. The service complied with the Accessible

Information Standard and relevant documents were available in formats to support people's understanding of them.

People's care needs were kept under regular review and changes were made when necessary. Appropriate assistive technology was used to support people's needs. The service liaised effectively with external health professionals to ensure people's healthcare needs were met.

People led fulfilling lives because they had access to a wide range of appropriate activities, community resources and events.

The service was well managed. Management had effective systems of governance to ensure its proper operation. Stakeholder's views about the service had been sought and acted upon.

Further information is in the detailed findings below.

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 rated Requires Improvement at the last inspection. At this inspection we found the areas of concern had been addressed. The service was now providing safe care.

Staff knew how to keep people safe and how to report any concerns.

Health and safety and individual risks were appropriately assessed and managed to minimise risk.

A robust staff recruitment process was in place.

People's medicines were safely managed on their behalf.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Dimensions 43 Clayhill Road

Detailed findings

Background to this inspection

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

The service was last inspected on 28 July 2015, when it was rated Good overall, with Requires Improvement (no breach), in Safe. This inspection took place on 23 and 24 November 2017 and was unannounced. It was carried out by one inspector.

The service had submitted a Provider Information Return (PIR), in October 2017. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help us plan the inspection.

Prior to the inspection we reviewed all the current information we held about the service. This included any notifications that we received. Notifications are reports of events the provider is required by law to inform us about. We contacted representatives of the local authority who funded people supported by the service, for their feedback.

During the inspection we spoke with the registered manager and four staff. We spoke briefly with three people and observed interactions between them and the care staff. We examined a sample of two care plans and other documents relating to people's care. We looked at a sample of other records to do with the operation of the service, including one recent recruitment record, training and supervision records and medicines recording.

Good

Is the service safe?

Our findings

At the previous inspection in July 2015 the service was rated Requires Improvement (no breach) in this domain. We had concerns because people were potentially charged for staff meals when being supported out in the community. We felt this could be discriminatory should people require two to one staff support and were concerned about potential inconsistency in the system's operation. We also felt some risk assessments were not sufficiently detailed or cross-referenced to people's care plans.

At this inspection we found these issues had been addressed. The provider had changed the policy on staff meals, when supporting people in the community and they were no longer charged to people. Risk assessments had been reviewed. They now contained sufficient detail and were referred to within care plans.

People said they felt safe in the service and staff also said this was the case. People's comments were, "Happy and safe," and "I'm safe." All staff had received regular training updates on safeguarding and the provider's whistle blowing procedure. Staff knew what management expected of them if they had concerns about abuse and were clear they would report any concerns. The necessary contact numbers were available on the office wall. Staff were confident any issues reported would be investigated and acted upon. No safeguarding issues had arisen since the last inspection and no concerns had been raised by staff, via the whistle-blowing procedure.

Risks to people and staff related to the environment and equipment were minimised because all required safety checks and servicing had taken place. Remedial action had been taken in a timely way where any issues were identified. Health and safety and fire risks were regularly reviewed. Steps were taken promptly where risks were identified. For example, a recent fire risk assessment review had identified the need for different internal handles to enable easy exit. The work was completed during the inspection along with other remedial works.

Individual risk assessments had been completed where risks to people had been identified. These mitigated the risk whilst minimising restrictions to people's freedom. They were linked to care plans and were regularly reviewed. One person had capacity to take decisions which might expose them to a degree of risk and had opted to do so as part of maximising their independence and mobility. A risk assessment had been completed regarding this, identifying the positive benefits to the person's mobility, which were felt to outweigh the risk, while the person was in the house. When the person was supported by staff to mobilise in the community, staff ensured appropriate steps were taken to reduce the risk of injury.

People experienced few accidents and incidents. Any which did occur were recorded via the provider's computer system and monitored centrally as well as by the registered manager. Standards of hygiene were observed to be good and appropriate personal protective equipment was available and used to reduce the risks associated with cross infection.

People were safeguarded because the service had a robust procedure for pre-employment recruitment

checks of potential staff. The required records of these checks were available to show the process had been followed. Appropriate information regarding the qualifications, employment checks and experience of agency staff, had also been received from external agencies.

People benefitted because the service had experienced low staff turnover. This helped to maintain continuity and consistency of care and ensured staff knew the people they supported very well. Staffing numbers were sufficient to meet people's needs. The usual staffing was two staff on each shift (early, late and night), with an additional staff member on a flexible 'middle' shift to help enable access to activities and the community. Additional staffing was provided for specific events.

The registered manager said that recruitment had been difficult at times due to the rural location of the service. Two 'bank' staff had been employed by the provider to help cover where permanent team members were unable to cover shortfalls. Agency staff had been used as a last resort at times, but regular individuals, familiar with people and the service, were used to minimise the impact on people. Reliance on agency staff had reduced recently to one or two shifts per week. There was one lead support worker vacancy for which interviews were due the week after inspection. A part-time support worker vacancy had been advertised without success to date.

People received their medicines when they needed them. The service used an effective monitored dosage system, which provided medicines within individual, labelled pots sealed by the pharmacist. Staff received training on medicines administration, which was refreshed annually.

Their competence with regard to medicines management was assessed annually to ensure correct procedures were followed. The registered manager said there had been no medicines errors since the last inspection. Monthly audits of medicines stock and records were carried out. The pharmacist also audited the services practice annually and had not raised concerns. The provider had adopted the NHS approved 'STOMP' policy (Stopping the Over-Medication of People with a learning disability). This entailed regular review of people's psychotropic medication (Medicines used to modify people' behaviour), with healthcare professionals. It had led to successful reductions in some people's medication, particularly where it impacted on their ability to enjoy a fulfilling lifestyle. Where people were prescribed medicines PRN (when required), they were given in accordance with individual PRN guidelines. However, some detail regarding people's medicines was recorded in their care plan, not immediately accessible to the staff member administering medicines. For example, information about the individual circumstances when the medicine was appropriate or how the person indicated they were experiencing pain. This issue had recently been identified as part of an in-house audit process and was due to be addressed imminently as part of the computerisation of people's care records.

Good

Is the service effective?

Our findings

People were still happy living in the service and three of them were able to tell us this. It was evident from observing people's reactions to staff they had positive relationships and sought out staff company and support. When they interacted with staff, people were smiling and their faces indicated a relaxed and familiar relationship. There was a sense people trusted the staff who supported them. One relative told us, "[Name] would tell us if he wasn't happy." An external care professional said, "This is their home, where they're safe and get on well with housemates." Another health professional described staff as, "Friendly and professional."

Staff communicated effectively about people's needs and daily records ensured important information was passed on between shifts. The provider was in the process of introducing a new computerised records system. This would further enhance recording and ensure people's individuality, interests, needs and wishes were fully recorded and accessible to the team via portable tablet computer. In future, staff would be recording information and observations via the computer tablet, which will also contain people's care plans and risk assessments. This information was in the process of transfer to the system. As part of the process a manager from another of the provider's services had visited and identified some straight-forward goals to set the service, regarding individuals, to familiarise staff with operating the system for the benefit of the people supported. For example, a goal had been identified for one person to be supported to go out Christmas shopping.

People had benefitted because staff were skilled at supporting them to increase their confidence. Effective long-term relationships with staff had also contributed to a reduction in challenging behaviour, such that behaviour support plans were no longer required where they had been necessary in the past. Staff had worked effectively over a period of two years to support one person to reduce their anxiety so they could access the community. They were now able to go on outings, attend a club in the community and had enjoyed holidays away. People were actively supported to maintain relationships with family and other people significant to them.

All staff had completed their Care Certificate induction. Staff continued to receive annual training updates, via a mix of e-learning and face-to-face training. The registered manager had obtained several sets of 'flash cards' on key learning areas to promote ongoing discussion and learning within team meetings. Eight of the ten staff had attained relevant care qualifications such as NVQ (National Vocational Qualification), or equivalent. Annual competency checks helped ensure staff put their knowledge into practice. Staff continued to receive ongoing support through regular supervision and annual appraisals. Immediate advice and support was also available out of hours, via the provider's telephone on-call system.

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. People were supported and enabled to make day to day decisions about their lives and their

consent was sought before staff provided care support. Each person was able to indicate their consent to day-to-day matters, using a variety of communication methods, with which staff were very familiar. Where people did not have capacity to make more complex decisions, best interest decisions had been made including relevant parties. For example a 'best interest' decision had been made to provide pureed meals for one person who was at risk of choking due to swallowing difficulties. Other best interest decisions had been made for individuals regarding flu injections, holidays and dental treatment.

People's rights were also safeguarded. One person had returned from hospital with a form (DNACPR), confirming they were not for resuscitation in the event of heart failure. On their return, their health prognosis was much improved and the service ensured the DNACPR had been reviewed by the GP and removed as a best interest decision. The service had worked with external professionals, including psychologists, psychiatrists an independent advocate and a solicitor to support another person to return home to live.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty 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 and found the service was working within the principles of the MCA. DoLS applications had been made for each person as all required one to one support to access the community.

People were involved in choosing meals for the menu and took part in shopping for and preparing meals as much as they wished to be. Alternative meals were always available where anyone didn't want the meal on the menu. Staff knew people's likes and dislikes well and would ask people what they wanted in advance, when they knew the menu item wasn't to someone's liking. We saw one person helping prepare the tea-time meal. Staff provided support to people at mealtimes where necessary and adapted cutlery and crockery were available to maximise independence. The provider's policy on funding staff meals when they ate with people they were supporting, had changed, and staff meals were no longer funded by the provider. This meant staff did not always eat with people which detracted somewhat from the sense of friendly enjoyment of meals together. This appeared out of step with other aspects of person-centred care which were provided well by the service. Special diets were provided for when necessary, with appropriate specialist guidance from the speech and language therapy team or dietitians.

People's health was monitored effectively. Staff knew them well and could identify when someone was 'under the weather'. The service had enjoyed a positive relationship with a local GP and had identified a dentist prepared to visit the service, where necessary, to ensure regular check-ups. People's health needs and appointments were recorded in individual health action plans.

The service was provided over two floors but did not have a lift. The group of people supported had been there for a long time and had increasing needs associated with old age, such as reduced mobility. The provider had begun to review this issue for the longer term. Some people already had ground floor bedrooms. The ground floor carpets had been replaced with vinyl flooring to enable people who mobilised via wheelchair, to propel themselves more easily. This meant they could maintain their independence. To support people who had difficulty mobilising, ceiling hoists had been provided in a bedroom and the lounge. A bath hoist was also available to those who need support. Staff were careful to keep the furniture layout consistent to support a person who was visually impaired maintain their independence.

Good

Is the service caring?

Our findings

The service remained good. Staff were seen interacting positively with the people they were supporting. They spoke respectfully to people, offered them choices, encouraged decision making and as much independence as possible. People's relationships with staff were seen to be positive. An external care professional told us, "All the staff are very caring and have a good relationship with [name]. There is a very good regular team with a very good relationship with clients and each other, working together well."

Staff worked with people in ways that respected their individuality and diversity. For example, one person's preference for a female GP had been respected and the GP practice had supported people by carrying out visits to the service when required. People's gender preferences with regard to the staff providing personal care support, were also respected. Staff spoke clearly about how they respected people's wishes, involved them and knew their likes and dislikes.

Materials produced by the service reflect appropriate diversity principles and were available in alternative easy to read or audio formats. Staff used a variety of communication aids to help ensure people were as involved in their care and decision making as much as they wished to be. For example pictorial menu options were used to enable people to make choices for the weekly menu. People's medicines were stored and administered in private in their bedroom. The registered manager told us no one had any identified spiritual needs but the service would have supported people to attend places of worship if they wished to.

The provider had established a 'Diversity Matters' group which met twice a year to monitor and discuss diversity issues. Any person supported by the provider could attend these meetings. The provider had appointed an Equality and Diversity advisor across its services to oversee the delivery of these principles. All policies and procedures were reviewed against the principles to ensure they take account of equality and diversity. All staff attended equality and diversity training.

People's end of life care wishes had been explored with them, with family support when a person wanted this. Appropriate funeral plans had been established with and external agency, based on people's wishes, some even included the music people wished to be played. Staff had worked positively with one person around the death of a parent, to enable them to understand what had happened.

Good

Is the service responsive?

Our findings

The service remained responsive to people's needs. People had detailed care plans which included information about people's needs as well as their known likes and dislikes about how they were supported. The care plans were supported by individualised risk assessments. Care plans and people's needs were regularly discussed within the staff team and reviewed with the person supported, and where appropriate, their family. Staff understood and supported people's individual communication methods to enable them to make choices and receive person-centred care.

A recent review of care plans as part of introducing computerised records included identifying specific goals for each person to further enhance their experience within the service. The intention was for staff to see this as an ongoing process to help them focus on continuing to develop people's skills and life experiences despite the ageing group in the service.

People's activity and entertainment preferences were well known by staff, most of whom had worked with them for an extended period. People had been supported to attend external events such as music concerts. People were also taken out regularly, for example, for meals, shopping trips, café visits or to attend clubs or day services. Transport was provided in the service's adapted minibus. People could go out either individually or in a group according to their preference. Weekly exercise and music sessions were provided by external specialists. People had also been away for holidays and short breaks with staff or family.

Within the house, sensory equipment had been used effectively to help one person to remain relaxed when not engaged in specific activities. One person enjoyed a combination of music and coloured lighting effects, which were provided in their bedroom. They could move in and out of their room freely but enjoyed spending time with the music and light show. A phone with attached video touchscreen was provided. People could identify who they wished to call from the photographs on screen and dial the pre-loaded number themselves by touching the photograph. This enabled them to remain in contact with people important to them more independently.

The service liaised effectively with external healthcare providers and other services when required to meet people's needs. For example, through contact with dieticians and the speech and language therapy service regarding people's dietary and swallowing issues. The service had also worked alongside the court of protection to maintain one person's rights.

The service complied with the requirements of the 'Accessible Information Standard', which is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information. Pictures, signs and photographs were used within care plans and other records to help people understand them. Records showed people had taken part in reviews of their care. Easy-read formats were used for things like the complaints procedure. People's ability to make choices around food was enhanced using pictures.

The service had easy-read and audio versions of the complaints procedure available. Four people would be

able to raise a complaint with support from staff. One person had an actively involved relative who would advocate on their behalf. No complaints had been made in the previous 12 months. Two compliments about the service had been received in the same period.

Good

Is the service well-led?

Our findings

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

The ethos of the service was one of individualised care delivered in a person centred way. This was reflected in the Statement of Purpose. People's individual needs, wishes and goals were identified, clearly documented and worked towards with people having as much involvement as they wished. People's records demonstrated their involvement and key records were in a more accessible format to assist staff with engaging people in decision making.

The planned move to electronic recording and storage of people's information was being introduced in a way whereby it would help staff identify immediate benefits and provide people with improved opportunities. The new system would store information about people's goals and identify upcoming appointments. Details of people's individual care needs and how they wished to be supported would be immediately available to staff without them having to refer to paper records in the office. Thought was being given to how the system could be used by staff to increase people's engagement and how the tablets should be used so as not to appear to exclude people in public.

The provider held monthly organisation-wide "Everybody Counts" meetings which any of the people receiving support could attend. One or two of the people at the service had attended these. The meetings were to discuss issue relating to equality and diversity issues and review policies and procedures.

The registered manager managed two registered services and three supported living houses, where people lived together with staff support. The registered manager split her time between services, spending two days in each registered location and was supported in each by a deputy manager, to ensure sufficient management presence.

The registered manager and provider had effective systems in place to maintain governance of the service. Where issues were identified, for example, through the fire risk assessment review, they were addressed in a timely way to maintain premises safety. The registered manager carried out periodic unannounced spot check visits to monitor service quality. To date these had not been specifically documented unless issues were identified for discussion in supervision or team meetings. The registered manager agreed to consider recording the visits under the new tablet-based system, to provide an audit trail of her monitoring. The recording system for staff training enabled the registered manager to monitor this and highlighted people due for refresher training three months ahead to allow time for its planning.

Staff received regular ongoing support through supervision and periodic team meetings. Team meeting minutes showed discussion or people's changing needs and appropriate topics related to quality care

delivery. Staff felt part of a positive, motivated and well-supported team. They felt the provider's vision and values were more proactive than in the past and the organisation was developing and moving forward. One member of staff described the service as a relaxed and well settled house and felt staff know the people they supported really well and people trusted the staff. The staff team was described as, "Positive," and team spirit was said to be, "Very good, it always has been." Another staff member felt the service offered people lots of opportunities and experiences and the new recording system would help evidence this effectively.

The views of people and their families had been sought via a quality survey, most recently in June 2017, with positive feedback provided. In response to people's feedback, additional activities opportunities had been explored. One relative commented, "[Name] has never looked so well and happy. [X] years of loving care and attention. I cannot thank you enough for all you do." A survey had also been sent to external professionals but none had responded.

A five-year development plan was in place and the service was two years into this with good progress made. A shorter-term service improvement plan for the period October 2017 to January 2018 was being worked on, relating to the introduction of the new recording system and progress was on schedule. Annual in-house audits were carried out to monitor and review progress. The registered manager received monthly support via supervision and off-site manager's meetings as well as informally within the provider's local registered manager's group.