Dimensions (UK) Limited

Dimensions Woodview 97 Wantage Road

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 03 March 2016. This was an unannounced inspection. Dimensions Woodview is registered to provide respite accommodation as well as emergency placements for up to five adults with a learning disability. People could have respite for a few hours a day or up to a week. At the time of the inspection there were five people using the service for varying periods of time.

There was a registered manager in post. 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 registered manager worked closely with an assistant locality manager.

People who were supported by the provider told us they felt safe. The staff had a clear understanding on how to safeguard the people and protect their health and well-being. There were systems in place to manage safe administration and storage of medicines. There were enough suitably qualified and experienced staff to meet people needs. The service had safe, robust recruitment processes.

Where risks to people had been identified, risk assessments were in place and action had been taken to reduce the risks. People had a range of individualised risk assessments to keep them safe and to help them maintain their independence. However, these were not always up to date. We gained assurance from the manager that these were under review.

People received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. The registered manager and staff understood their responsibilities under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may lack the capacity to make their own decisions.

People were supported to have their nutritional needs met and were supported to make healthy meals. People were given choices. Staff knew people well, understood their individual preferences and unique ways of communicating.

There was a calm, warm and friendly atmosphere at the service. Staff were motivated and inspired to give

kind and compassionate care. Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records.

People and relatives told us they were confident they would be listened to and action would be taken if they raised a concern. Complaints were dealt with in a compassionate and timely fashion. The service had systems to assess the quality of the service provided. Learning was identified and action taken to make improvements which improved people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

The service had good quality assurances in place and the registered manager used these to develop and improve the service. Staff spoke positively about the management and direction they had from the manager. The service had systems to enable people to provide feedback on the support they received.

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 individualised risk assessments in place.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse. Staff understood their responsibilities in relation to safeguarding.

Medicines were administered and stored safely.

Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs.

People were supported to have their nutritional needs met.

Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards.

People were supported to access healthcare support when needed.

Is the service caring?

Good

The service was caring.

People were supported by caring staff who treated them with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

Visitors to the service spoke highly of the staff and the care delivered.

Is the service responsive?

Good

The service was responsive.

People received activities or stimulation which met their needs or preferences.

People's care plans and risk assessments reflected their needs. However, these were not always up to date.

People knew how to raise complaints and concerns

Is the service well-led?

Good

The service was well led.

Incidents and accidents were recorded. There were follow ups, outcomes or action plans.

Staff spoke positively about the team and the leadership.

There were systems in place to monitor the quality and safety of the service and drive improvement.

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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 took place on 03 March 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection we reviewed the information we held about the service and the service provider. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We contacted commissioners of services to obtain their views on the service on the quality of the service provided to people and how the home was being managed.

During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the manager and two members of care staff. We reviewed a range of records relating to the management of the home. These included five staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We spoke with four people and three relatives. We looked at three people's care records including medicine administration records (MAR).

Good

Our findings

People felt safe when staying at Dimensions Woodview. People were comfortable in approaching and interacting with staff. Relatives told us their family members were safe. Comments include, "It's very safe at Woodview. I would not leave my child if it wasn't", "If it was not safe I would never leave my daughter there. Staff are good with her".

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments included areas such as physical harm, safety when showering, accessing the community and financial abuse. Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. For example, one staff member told us they supported a person when they went out to ensure their safety.
Ways of reducing the risks to people had been documented and staff knew the action they would take to keep people safe. Records showed people had Personal Emergency Evacuation Plans (PEEP) in place.

Staff were knowledgeable about the procedures in place to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service's safeguarding and whistleblowing procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us, if they had a concern, they would "check with the manager and report it". Another staff member said they would complete a "body chart" (if appropriate) and an incident accident report. They would also refer to the local authority safeguarding team.

We looked at the arrangements for safeguarding people's money. Where a person was unable to manage their own day to day pocket money and expenses due to a lack of understanding, appropriate arrangements were in place for staff to manage their finances. All money spent on behalf of people was recorded and receipts were obtained. The registered manager conducted audits of people's finances to check the services policy on handling people's money was followed. The system protected people effectively from the risk of financial abuse. The registered manager told us they were looking at providing individual safes in people's rooms so people could safely keep their own money.

People were supported by sufficient numbers of staff with the skills and knowledge to meet their individual needs. Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The service used a dependency assessment tool at the beginning of care

provision as well as every three months to assess the need for staff adjustment. The manager considered sickness levels and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels. One member of staff told us, "It would be nice to go above and beyond". The member of staff explained that as a service they were providing good care but aiming at providing outstanding care and this was achievable through provision of more staff.

Safe recruitment procedures were followed before staff were appointed to work at Dimensions Woodview. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. For example staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Medicines were stored and administered safely. There was an up to date medicine policy which included an easy read version suitable for people with learning disabilities. People received their medicines when they needed them. Records showed staff administered medicines to people in line with their prescription. There was accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or if not taken the reason why. All staff who administered people's medicines had received training to do so and their competency was assessed.

The environment was clean and tidy and there was a homely feel. One relative told us, "The staff are amazing. They keep the place clean". Staff were aware of the providers infection control polices and adhered to them. Equipment used to support people's care, for example, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. Where people had brought in their own wheelchairs, checks had been conducted to ensure they were safe to use. We observed staff using equipment correctly to keep people safe.

Good

Our findings

Staff were knowledgeable and skilled to effectively carry out their roles and responsibilities. One person commented on staff skills, "They (staff) are good and well trained."

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were safe and sufficiently skilled to carry out their roles before working independently. Staff comments included, "Some mandatory training topics are taken via e-learning and others are done face to face" and "I am halfway through a National Vocational Qualification (NVQ) in health and social care level 2 programme". Staff were not expected to deliver care independently until they were prepared and confident to do so. They would initially be involved in supporting people with activities, moving on to assisting with personal care at a later stage when they had a rapport with the person.

Staff had completed the providers initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. A member of staff told us they had taken courses on autistic spectrum disorder and intensive interaction which "has been brilliant". Intensive Interaction is a practical approach to interacting with people with severe or profound and multiple learning disabilities and/or autistic spectrum disorder. Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and could identify any need for extra training.

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. Staff told us they had regular monthly one to one supervision meetings with their line manager which were helpful to their practice. Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervisions. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans formed part of the annual appraisal process.

People's specific dietary needs were met. Staff had the information they needed to support people. Some people had special dietary needs and preferences such as diabetic diet, soft food where chocking was a risk or low fat diet where weight management was an issue. For example, a person's support plan indicated the person was to be supported to have low fat diet to aide weight loss. We observed staff prompting this person to choose food that was low in fat. Where some people had lost weight there was a plan in place to

manage weight loss. The home contacted GP's and care home support if they had concerns over people's nutritional needs. We observed snacks were available for people throughout the day, such as fruit and biscuits.

During lunch time we observed people being supported with making their meals. People chose what they wanted for lunch and where they wanted to sit. People were prompted to make meals of their choice by attentive staff. The kitchen had pictures on cupboards showing what was inside making it easier for people to locate food and utensils. We observed staff sitting with people and talking to them whilst prompting them to have their meals at a relaxed pace.
Professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. These included the GP, professionals from the Community Learning Disability Team and social workers. A member of staff told us, "We work in partnership with a lot of organisations". The home referred people to the local Community Learning Disability Team and local day care providers as services involved in supporting people.

People's consent was sought before care or support was given. Staff told us they would explain care to be given and seek the person's consent to that care. We observed staff knocking on people's doors and seeking verbal consent whenever they offered support interventions. We also saw in support files that people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance where people lacked capacity. For example, all files reviewed showed consent for taking and using photographs. Staff told us consent was always sought and the response was not necessarily obtained verbally. Staff observed people's body language which determined if a person was happy with the support offered.

Staff were aware of their responsibilities under the Mental Capacity Act 2005(MCA). The MCA provides a legal framework to assess people's capacity to make certain decisions at a certain time. 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 were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity, there was evidence of decisions being on their behalf by those that were legally authorised to do so and were in a person's best interests.

Staff had a good understanding of their responsibilities under the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. One member of staff told us "They can't just lock the door or keep them shut in". The manager told us there were no DoLS authorisations in place. However, some people were waiting for a DoLS authorisation to come through. Staff knew how to support these people in the least restrictive way.

Good

Our findings

People were positive about the care they received. Comments included, "It's nice here. You go out sometimes for coffee", "I like it here" and "[staff name] helps me". People's relatives told us, "I have been impressed by staff. They are really caring", "They are caring and they know the people who use the service well" and "Staff are a godsend and very kind".

We observed many caring interactions between staff and the people they were supporting during our inspection. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and laughter throughout the day. People were being supported in recreational activities. For example, we observed a member of staff supporting a person to paint picture using palms and fingers. Staff engaged with the person by listening and talking, and by using non-verbal communication including touch. Support staff clearly had a good rapport with the person. Staff had also supported this person to make a birthday card for a family member. The person proudly showed us the card. We spoke to another person who did not reply but made eye contact with us. They were smiling, relaxed and clearly comfortable at the service.

People were actively involved in staff interviews and were included in the interviewing panel. The registered manager said it was important for people to be involved in recruiting staff as they would be the one's receiving care from them. People told us they enjoyed being part of the interviewing panel.

Staff told us they enjoyed working at the service. One member of staff said, "It's a lovely job". Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted in a patient way offering choices and involving people in the decisions about their care. People were given options and the time to consider and to make a choice.

Staff were respectful in their approach to ensure people were not distressed or worried by having a team of inspectors in their home. The inspection team was introduced to people throughout the day. Staff took time to explain the purpose of our visit to people and sought people's consent for us to speak with them. Staff told us how each person preferred to communicate and shared any special methods of communication such as by body language and hand signals to ensure we were able to obtain views from all people including those who could not communicate verbally. Understanding people's specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care.

Staff were aware of people's unique ways of communicating. For example, if one person followed staff

members around holding hands up as if to be 'high fived', staff knew this meant the person wanted undivided attention at that moment. We observed staff communicating with people using Makaton. This is a language programme using signs and symbols to help people to communicate. It is designed to support spoken language and the signs and symbols are used with speech, in spoken word order. Care plans contained information about how best to communicate with people who had sensory impairments or other barriers to their communication. One person's relative told us communication through dairies for people who could not speak had previously not been very good but was now improving. They told us, "Sometimes there were no diary entries and the day centre had to call staff to get updates. This could have led to misinterpretation in change of behaviour for a person who does not speak". These concerns had been addressed by the registered manager.

People were treated with dignity and respect by staff and they were supported in a caring way. Staff ensured people received their care in private and staff respected people's dignity. Staff described how they treated people with dignity and respect. Comments included "I treat them like I would like to be treated" and "I respect their (people's) privacy".

Staff understood and respected confidentiality. Comments included, "We only discuss confidential information on a need to know basis" and "I make sure confidential information like support plans are kept secured". Records were kept in locked offices only accessible to staff.

Each person's support plans detailed the importance of people maintaining their independence where possible. Staff told us people were encouraged to be as independent as possible. One member of staff told us, "It's important not to takeover. We let them do as much as they can". Records showed people's independence was promoted. For example, one person had prompts in their care plan to 'support to independently prepare snacks and drinks'. We saw this person being prompted to make their own snacks and drinks.

Good

Our findings

During our inspection we reviewed four support plans. The risk assessments and support plans had not been updated as per provider policy. These risk assessments are meant to be reviewed every year but all four we looked at had not been updated in two years. The registered manager told us people's needs had not changed and therefore the impact of the risks was low. Two people's support plans had not been updated in over a year. There was a lot of duplicated and old information that required archiving. We discussed these concerns with the registered manager who told us they were in the process of archiving and updating all support plans as well as risk assessments. They told us they had identified this as a priority since they came into post. The registered manager assured us they would complete this process by the end of April 2016.

People's needs were assessed prior to accessing the service to ensure their needs could be met. The registered manager met with people and their relatives to do these assessments. The assessments were used to create a person centred plan of care which included people's preferences, choices, needs, interests and rights. The provider used a matching support document to match people with staff who had similar personality characteristics as well as common interests. For example, one person had interests in shopping, dancing and music. They were matched to a member of staff who had said they shared these interests. The manager ensured the staff member was on duty on the days the person attended the service.

Support plans focused on people's personal history. People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person did not like being directed what to do. We saw staff asking this person what they wanted to do rather than tell the person what to do. The care records that we reviewed reflected that care was centred on people's individual views and preferences. People knew their keyworkers and worked very closely with them as well as relatives to ensure support planning was specific to each individual.

Records showed where appropriate, people's relatives signed documents in care plans to show they wished to be involved in the plan of care. Relatives told us they had been involved in developing care plans and reviewing care. One relative said, "We are involved in the planning of care to allow continuity from when they leave respite for home. Change of routines could easily trigger change in behaviour".

People's wishes and preferences were used to identify activities of interest for people. This involved a number of social groups and activities of their choice such as swimming, shopping, and puzzles. We

observed one person who liked helping with household chores being supported to do so safely. One person told us they, "Enjoyed going for a pub lunch, visiting a local beauty spot 'Wittenham Clumps' and going shopping in Oxford".

Feedback was sought from people through regular relatives and residents meetings as well as quality assurance surveys. Records showed that some of the discussions were around what suggestions people had to make improvements to the service. The provider held an annual event 'Everybody Counts' which provided an opportunity for people and their relatives to feedback at a higher level within the organisation.

People and their relatives knew how to make a complaint if required and were confident action would be taken. The provider had a complaints policy in place. There was also a complaints procedure for people in 'easy read' format (simple, clear English supplemented by photographs). One person told us if they were not happy with something, "You'd tell the staff". Staff were clear about their responsibility and the action they would take if people made a complaint. Any minor complaints raised were quickly dealt with. Any concerns received about the quality of support were investigated thoroughly and recorded. The registered manager discussed concerns with staff individually in supervisions and more widely at team meetings to ensure there was learning and to prevent similar incidences occurring.

Records showed complaints raised had been responded to sympathetically and followed up to ensure actions completed. Relatives spoke about an open culture and felt that the home was responsive to any concerns raised. Relatives told us, "I can complain to the manager if I have any issues", I know how to raise concerns. I will call social services" and "I know the manager and staff well so I will tell them if something is not right". Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received. Staff told us they had received compliments such as thank you cards and flowers.

Good

Our findings

The service was led by the provider and registered manager who had been in post for two months. However, they had worked with the provider for eleven years. The manager had good support from an assistant locality manager who was working between two services.

At the time of our inspection, the manager had only been in post for two months. There had been significant changes seen since the manager's appointment. The manager told us, "There is a lot of work to be done to get this service to the standards we want it to be". The manager told us their biggest challenge had been the support plans and risk assessments which were not up to date.

Some relatives had previously raised concerns about the communication with the staff. However, they told us since the leadership changed, the communication had improved. Comments included, "We have seen huge improvements since the new manager", "We have noticed some changes" and "My expectations have gone up recently". We found the registered manager and senior staff to be open and transparent about the service and the improvement still required.

The registered manager had an open door policy, was always visible around the home and regularly worked alongside staff. People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. For example, residents and relatives meetings were held regularly and relatives could drop in anytime to speak with the registered manager. Relatives told us, "We have meetings regularly and we get newsletters for updates". Records showed the registered manager also facilitated monthly staff and residents meeting. In one of the meetings people had said how much they liked the unit but also wanted new sofas and chairs. We saw these had been provided.

Staff held monthly meetings. These meetings were used to discuss areas of improvement, CQC updates and cascade any changes. Staff meeting minutes reviewed showed action plans after each meeting. For example, one meeting action plan was for staff to have activity rotas. Records showed this action plan had been completed. Staff were encouraged to read about CQC outstanding services and come up with innovative ways of improving their own service.

Staff we spoke with felt the service was well led. They told us they had good relationship with the manager. Staff comments included, "Manager is really supportive", "Manager is always at the end of a phone if needed", "The manager is very compassionate" and "Manager is good with one to ones (supervision) and staff meetings"

Staff described a culture that was open with good communication systems in place. Staff told us they had a good handover system which ensured information was shared effectively. Staff also said, "The team is really good" and "We get updates regularly". Staff felt motivated to improve the service provided for the people. The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. The provider had good quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, environmental safety and levels of residents need. Results of audits were discussed in staff meetings and individual areas for improvement were addressed with staff during their supervisions. Records showed local pharmacies had been involved in audits twice every year. These audits had identified some areas of improvements and these findings had been used to make positive changes within the service. For example, the service had developed a MAR chart more suitable for respite care.

There was a clear procedure for recording incidents and accidents. Any incidents and accidents relating to people who used the service were recorded and investigated. The results of investigations were analysed by the registered manager to look for patterns, trends and risks or what changes might be required to make improvements for people who used the service. Learning from accidents and incidents was shared throughout the service. Staff told us there was online accident/incident reporting guidance. The provider's accident/incident reporting policy included a declaration of six 'never events' or things that should never happen. For example, no person with epilepsy would have a bath unsupervised and no person will suffer adverse consequences (serious harm) from failure to administer prescribed medication appropriately. This highlighted what the expectation was for staff in relation to maintaining people's safety.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. One member of staff said, "I can raise concerns or whistle blow if I have to. We all have the contact details". Another member of staff said, "I would probably go to my manager if I have any whistleblowing concerns". They also mentioned a confidential hotline they could call.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager was aware of their responsibilities and had systems in place to report appropriately to CQC about notifiable events.