Dimensions (UK) Limited

Dimensions 11 Kilford Court

Inspection report

11 Kilford Court
Botley
Southampton
Hampshire
SO30 2TN

Tel: 01489790949
Website: www.dimensions-uk.org

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 31 January and 2 February 2017. The inspection was unannounced.

Dimensions are a specialist provider of a wide range of services for people with learning disabilities and people who experience autism. 11 Kilford Court provides care and support for up to six people with a learning disability. At the time of our inspection there were four people living at the home some of whom were also living with physical disabilities and with dementia. The home is arranged over two floors. The ground floor consists of four bedrooms, a dining and kitchen area, a laundry room and a communal lounge which also had a sensory area. There is also an adapted bathroom and a level access shower room on this floor. This floor is fully accessible to wheelchair users. Two further bedrooms and the office and staff sleep in room were located on the first floor which were accessed by stairs only. The home has a large accessible garden to the rear and parking to the front.

The service had a registered manager. 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 and associated Regulations about how the service is run. The registered manager also managed another Dimensions services and was supported in their roles by an assistant manager.

At the last inspection in January 2016, the service was rated "Requires Improvement" overall and there were breaches of Regulations associated with managing risk and ensuring staff had received appropriate support. At this inspection, we found that improvements had been made and the service was now "Good" overall with no breaches of legal requirements.

Since our last inspection, improvements had been made to ensure that risks to people's health and wellbeing were adequately assessed and planned for. Staff were now receiving regular supervision and were being supported to undertake nationally recognised qualifications.

The registered manager was taking robust action to ensure the landlord took timely action to make improvements to the property.

Staff spoke positively about the leadership of the service. Morale was found to have significantly improved with staff telling us that the registered manager worked effectively with them and encouraged them to express their views about how the service might improve.

Improvements had been made which helped to ensure people's rights were protected. Staff had acted in accordance with the requirements of the mental capacity act and the Deprivation of Liberty Safeguards (DoLS). Where people were able to express choices, these were respected.

Whilst each person had an individualised weekly plan of activities, more could be done to enhance the

quality of interactions with people and offer more varied and meaningful opportunities for active support.

Staff were trained in how to recognise and respond to abuse and understood their responsibility to report any concerns to their management team.

Appropriate arrangements were in place to manage people's medicines. Medicines were only administered by staff who had been trained to do this.

There were sufficient staff to meet people's needs and safe recruitment practices were followed.

Staff received a range of training which enabled them to provide people with appropriate care.

People were supported to have enough to eat and drink. Staff recognised when people's physical health needs changed and ensured that relevant referrals were made to health care professionals.

Staff showed people kindness, patience and respect. Staff demonstrated a good knowledge and understanding of the people they were supporting. They were well informed about people's communication needs and used this effectively to provide person centred care.

Staff demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

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.

Risks to people's health and wellbeing were adequately assessed and planned for.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect. Staff were clear about what they must do if they suspected abuse was taking place.

Staffing levels were adequate and enabled the delivery of care and support in line with peoples assessed needs.

Medicines were managed safely.

Is the service effective?

Good

The service was effective

Staff were supported to provide appropriate care to people because they were suitably trained, supervised and appraised.

People's rights were protected because staff had acted in accordance with the requirements of the mental capacity act and the Deprivation of Liberty Safeguards (DoLS). Where people were able to express choices, these were respected.

People were supported to have enough to eat and drink.

Staff recognised when people's physical health needs changed and ensured that relevant referrals were made to health care professionals.

Is the service caring?

Good

The service was caring.

Staff showed people kindness, patience and respect. Staff demonstrated a good knowledge and understanding of the people they were supporting. They were well informed about people's communication needs and used this effectively to

provide person centred care.

People were treated with dignity and respect and were encouraged to live as independently as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Whilst each person had an individualised weekly plan of activities, more could be done to enhance the quality of interactions with people and offer more varied and meaningful opportunities for active support.

People's care and support plans were personalised and their preferences and choices were detailed throughout their care records. This supported staff to deliver responsive care.

Complaints policies and procedures were in place and were available in easy read formats.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the leadership of the service. Morale was found to have significantly improved with staff telling us that the registered manager worked effectively with them and encouraged them to express their views about how the service might improve.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

Dimensions 11 Kilford Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also checked whether the provider had the made the required improvements following our last inspection in January 2016.

The inspection took place on the 31 January and 2 February 2017 and was unannounced. The inspection team consisted of one inspector.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is used by registered managers to tell us about important issues and events which have happened within the service. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, such as what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

Due to nature of the needs of people using the service, we were not able to seek their views about the care and support they received. We were however, able to speak with one relative and one person's informal advocate. We also spent time observing interactions between people and the staff supporting them. We spoke with the registered manager and four support workers. We reviewed the care records of two people in detail. Other records relating the management of the service such as audits and policies and procedures were also viewed.

Following the inspection we sought feedback from four health and social professionals about the quality of care people received.

The last inspection of this service was in January 2016 during which we found two breaches of the legal requirements. This inspection found that the required improvements had been made.

Good

Is the service safe?

Our findings

People were not able to tell us whether they felt safe living at Kilford Court, but our observations indicated that people felt secure in their surroundings and were comfortable with the care and support provided to them by the staff team.

At our previous inspection in January 2016, we identified a breach of Regulations associated with the management of risks. At this inspection, we found improvements had been made to ensure that risks to people's health and wellbeing were suitably managed. This requirement was now met.

Improvements had been made to ensure that risks to people's health and wellbeing were suitably managed. Each person had a risk analysis which identified the areas where specific risk assessments were required. Individual risk assessments were then prepared by the staff supporting the person. Areas covered included moving and handling, epilepsy, nutrition, risk of abuse or isolation and the risk of falls. It was evident that action was being taken to manage people's risks. For example, following a fall, staff had installed a sensor mat to alert them that the person had got out of bed. This triggered a pager worn by staff who could then go and assist the person in a timely manner. We did note that the service did not currently use a post falls protocol. This was discussed with the registered manager who made arrangements for this to be put in place.

Some people using the service had been diagnosed with oral dysphagia and required a modified diet. (Dysphagia is the medical term for swallowing difficulties). Where this was the case, relevant guidance about their dietary needs was readily available in the kitchen. We spoke with an agency care worker who was undertaking their first shift within the home and found they had been fully briefed about people's dietary needs. Guidance was readily available which documented how staff should provide emergency first aid in the event of a person choking. We spoke with a number of staff about how they would respond to an incident of choking. They all confirmed that they had received training in this area and explained the actions they would take. We did note that the guidance for one person would benefit from being updated to take into account the fact they spent most of their time in a wheelchair and might need a slightly different approach to emergency first aid. We spoke with the registered manager who took prompt action to ensure the guidance was updated.

The service had a 'Read and Sign File' which contained key information about people's risks or updates to their care plan. For example, it contained an update about one person's dietary needs and new or updated policies. Staff were required to read this and sign to confirm they understood the information. The service had systems in place to report, investigate and learn from incidents and accidents. There was evidence that following an incident, the potential cause was investigated and appropriate actions taken in response. The organisation was committed to ensuring that people were protected from 'never events'. Never events are significant, largely preventable safety incidents affecting people who use the service, which should not occur if the available preventative measures have been implemented. Each staff meeting was used to reflect upon six 'never events' and the actions staff should take to ensure these never occurred.

People's medicines were managed safely. Staff who administered medicines had completed training and competency assessments were carried out to ensure they remained safe to administer people's medicines. Appropriate arrangements were in place to order and store people's medicines which were kept safely in locked cabinets in people's rooms. We carried out a stock check of Controlled drugs. We reviewed two people's medicines administration record (MAR). These contained sufficient information to ensure the safe administration of medicines. Two staff were required to sign the MARs, one to confirm they had administered the medicine and a second care worker to confirm they had witnessed this. A review of the MARs showed one gap, where the person witnessing the administration of a medicine had not signed to confirm this. The registered manager told us this would be investigated. Records showed that where there had been previous medicines errors, investigations had taken place and the staff members concerned reassessed as competent before they could recommence administering medicines. We did note that some of the protocols in place for the use of 'as required' or PRN medicines could be more detailed. For example, people would not have been able to verbally communicate that they were pain, but might display particular behaviours that would indicate this. The current PRN protocols for pain relief did not include this information which would be helpful to less experienced or agency staff. Arrangements were in place for the temperature of the cabinets used for storing medicines to be monitored daily; however this was not always taking place. Storing medicines within recommended temperatures is important as this ensures that they are safe to use and remain effective.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. The organisation had appropriate policies and procedures in relation to keep people safe. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. Staff were confident that registered manager would take action if they brought concerns to their attention. The service had a dedicated whistle-blowing line and information about this was displayed within the staff sleep in room. Staff told us they were aware of the whistle-blowing line and would use this to report concerns about poor practice. They were also aware of other organisations with which they could share concerns about abuse.

Staffing levels were adequate and allowed people's needs to be met. During the day the minimum staffing levels were three support workers. At night there were two staff, one sleeping and one awake. The registered manager told us the staff rotas were determined by the commissioners of people's placements within the service. All of the staff we spoke with told us the staffing levels were adequate to meet people's needs safely. We reviewed the staff rotas for the week of the inspection and the previous 3 weeks and saw that these demonstrated that the home was staffed to at least the levels described above.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity checks, obtaining appropriate references and Disclosure and Barring Service checks. Interviews were competency based and required prospective staff to demonstrate how they would work in a manner that was in keeping with the provider's values such as dignity in care and protecting people from harm. Job candidates visited the house to meet the people they would be supporting and to demonstrate that they were able to effectively communicate and engage with each person. These measures helped to ensure that only suitable staff were employed to support people in their homes.

The home environment was overall, clean and tidy. One person's room smelled of urine due to ongoing problems with incontinence, but there was evidence that staff were taking action to try and address this and ensure the environment remained suitable for the person. We observed that staff were aware of infection control procedures. Protective clothing was available and used by staff when needed. Training records showed that most staff had completed training in infection prevention and control in 2016.

Good

Is the service effective?

Our findings

When we last inspected the service in January 2016, we found that staff were not receiving the support and supervision they needed to ensure they were suitably skilled and competent to carry out their roles. This inspection found that the required improvements had been made.

As part of their induction, new staff were now being supported to complete the Care Certificate. The Care Certificate was introduced in April 2015 and sets out explicitly the competencies and standards of care that new care workers are expected to demonstrate. A new member of staff had been enrolled on the Care Certificate and was completing workbooks in order to demonstrate their skills and knowledge. The workbooks were being reviewed by the registered manager to ensure the care worker had demonstrated they were competent to carry out their role. Staff also continued to be provided with a service specific induction which included an opportunity to complete some essential training, read the organisations policies and procedures and the care plans of the people they would be supporting. Agency staff also completed an induction to the service. An agency care worker told us, "I was welcomed, the staff introduced themselves, I was showed the fire drill arrangements, read the policies and care plans, I am very clear about [people's] dietary needs…the induction was adequate for my purposes".

Records showed that staff were now receiving more regular supervision. Supervision and appraisals are important tools which help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The supervision records viewed were robust and demonstrated that the training and development needs of staff were being considered and any performance concerns addressed in a supportive manner. One staff member told us, "Supervision is a lot more regular, the management are more available". Staff also had an annual appraisal which included feedback on their performance from people, their peers, family members and other professionals. This helped to ensure that the process was meaningful and any training needs identified.

Staff completed a range of essential training. Most of the training programme was delivered by e- learning and was repeated either annually or every three years. Training provided included manual handling, basic first aid, basic food hygiene, health and safety, fire training, MCA 2005, equality and diversity, person centred care, nutrition and safeguarding people. Staff also had additional training relevant to the needs of people using the service. For example, staff had completed training in epilepsy and caring for people living with dementia. Staff were positive about the training available and told us it helped them to perform their role effectively and was relevant to the needs of people using the service.

People's rights were protected because staff had acted in accordance with the requirements of the mental capacity act and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people used specific techniques to indicate their choices or consent, these were described in decision making agreements. For

example, we saw that one person would indicate they did not want to do a task or activity by lowering their head. Staff were reminded of the importance of helping the person make choices by using short sentences, key words and only offering a few options at a time. When people were unable to make more complex decisions about their care, staff were guided by the principles of the Mental Capacity Act (MCA) 2005. Staff were aware that decisions made on behalf of people must be in their best interests and made in consultation in relevant persons. Senior staff had completed and documented mental capacity assessments to determine whether people could consent to the care and support being provided and to living at the service and there was a record of the decisions been made in the person's best interests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Each of the people living at the service had an authorised DoLS in place. In the case of three people, a relevant person's representative (RPR) had been appointed to help ensure the person's rights and choices were being safeguarded and that staff were not following overly restrictive practices when providing care.

We looked around the premises and examined records in relation to the maintenance of the building. We found that in general the premises were of a suitable design and layout to meet the needs of people. A number of improvements had been made since our last inspection. The lounge had been redecorated and new carpets and sofas put in place. A gardener had been employed to help maintain the grounds and a fish pond created with people getting involved feeding the fish. However we noted that some fixtures and fittings were still in need of maintenance or repair. For example, the kitchen units and work surfaces were worn, exposing the chip board below. This would make the surfaces difficult to clean and pose an infection control risk. The provider did not own the premises and repairs and improvements to the property were the responsibility of their landlord. We were able to see that the registered manager was taking robust action to ensure the landlord took timely action to make the required improvements to the property.

People were supported to have enough to eat and drink. Due to people's communication needs, the weekly menu was planned by staff based upon people's known likes and dislikes. The menu was displayed on the fridge and appeared to be a varied and suitable diet to meet people's needs which included some fruit and vegetables. Nutritional needs were assessed and 'How I eat and drink' plans were in place which described any specific dietary requirements such as whether the person needed a modified diet, or adapted cutlery. The support of the GP, dietician and speech and language therapy services was sought, as required. For example, one person had been prescribed high calorific drinks due to their weight loss. This person was also being weighed on a weekly basis and records were being maintained of the food and fluids they were offered. We did note that other people had been assessed as needing their weight to be monitored on a monthly basis and this was not always taking place. The registered manager advised that staff would be reminded of the importance of completing this.

Where necessary staff had worked effectively with a range of other healthcare professionals to help ensure that people's physical and mental health care needs were met. This included GP's, learning disability nurses, physiotherapists, occupational therapists and community nurses. Staff were being trained by a healthcare professional to provide one person with a specialist programme of exercises to assist with improving their mobility. Staff had advocated for one person to have a new wheelchair which appeared to have increased their comfort. People had attended dental and optician appointments and been referred to dieticians for healthy eating advice. Staff were effectively contributing to multi-agency care programme approach (CPA) meetings. CPA meetings are a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

People had health action plans (HAP). A HAP holds information about an individual's health needs, the professionals who are involved to support those needs and hospital and other relevant appointments. It was evident that due to their knowledge of people, their normal routines and demeanour, staff were able to pick up any changes in a person's well-being and respond appropriately by ensuring referrals were made to relevant health care professionals. A health care professional told us, "Staff appear to be proactive in noticing declines in people's physical health and accessing the GP where appropriate". They told us that staff had identified that one person was experiencing pain and had supported the person to visit the GP regarding this. Following reviews by healthcare professionals, staff completed a practitioner's report which documented any changes to the person's treatment pathway or support plan. Some of the health and social care professionals we spoke with felt communication between staff was an area where improvements could be made. To address this, the registered manager had introduced a new, more detailed handover which ensured information such as changes to people's wellbeing or incidents that had occurred was shared effectively.

Good

Is the service caring?

Our findings

Relatives were positive about the caring approach of staff at Kilford Court. One relative told us, "Oh yes they are kind, very considerate toward [the person], they can't do enough for him". An advocate told us, "Definitely [staff are kind and caring] I have never seen anything different…it's a lovely atmosphere there".

People living at 11 Kilford Court were not able to tell us how caring the service was so we spent time observing their care and support. Our observations indicated that staff showed people kindness, patience and respect. Many of the staff had worked at the service for many years this had allowed them to build up relationships and trust with people. Staff talked to people in a friendly and calm manner and this helped to create a relaxed atmosphere within the service. A member of staff told us, "Yes all the staff are kind and caring here, if they weren't I would have a word with the manager and she would act".

Staff demonstrated a good knowledge and understanding of the people they were supporting. They told us about their personalities and attributes. They were informed about the things that might cause upset or anxiety to people and took action to limit this. For example, the first day of the inspection was busy with lots of visitors. Staff were aware that this might cause some people to be a little more anxious than normal and so they ensured people were assisted to undertake relaxing activities such as using the sensory room. A healthcare professional told us, "Staff appear to know service users well, positive interactions have been witnessed".

People had a 'How I communicate support plan' which gave guidance for staff on how to understand how the person made choices and how they communicated these. For example, one person's support plan explained that shouting meant they wanted to go out. Another person's communication plan explained how loud vocal sounds might indicate the person was in pain At lunchtime, we saw staff offering people juice or tea and waiting patiently for the person to respond. Staff told us this person would turn their face away if they did not want something. A care worker told us how another person would lift their hand to their mouth if they were hungry. They told us, "[the person] will make choices, we give him a range, one at a time and use pictures to help". Our observations indicated that staff were well informed about people's communication needs and used this effectively to provide person centred care. Where staff were facing increasing challenges with regards to communicating with people effectively, we saw that specialist advice and support had been sought with the aim of enhancing interactions.

Staff supported people in a way that maintained their independence. For example, we observed that staff gave one person just the right amount of support to enable them to eat as independently as possible using the 'hand over hand' techniques described in their care plan. Another person was encouraged to take their tray to the dishwasher once they had eaten their meal. A staff member told us how one person liked to put their own clothes in the washing machine each day and so they were encouraged to do this. This had become harder over recent months following a decline in the person's health, but staff were still aware that doing this was important to the person and tried wherever possible to encourage him to continue to do this.

People were encouraged to make the service their home. Each person's room was decorated according to their own style and looked homely and comfortable. Staff supported people to keep in touch with family members. For example, staff took one person to spend the morning with a relative, which they were known to value. The relative told us, "I am more than happy, "We've been out this morning, they [staff] come and pick me up and, take us to [a local café], leave us there for a while to spend some time together, I can't fault it". The relative had also been invited to the service to spend Christmas with their family member which they had enjoyed. Where people had lost contact with family members, staff were, where appropriate offering support to reunite people with their relatives.

Staff we spoke with during the inspection demonstrated a good understanding of the meaning of dignity and how this encompassed all of the care provided to each person. Staff told us they were careful to ensure people's doors were closed when providing personal care and knocked on people's doors before entering their rooms. A healthcare professional told us, "Staff do maintain service users dignity when attending to personal care…respect is upheld from my observations". Arrangements were being made to work with people, their relatives and advocates and healthcare professionals to develop end of life care plans which gave the person, as far as possible the opportunity to plan and make choices about how and where they would like their care to be managed and what they would like to happen after their death.

The service had a range of accessible communications available to ensure people were enabled to be involved in decisions about their care and the policies and procedures of the organisation. For example there were easy read versions of people's support plan agreements and 'What Dimensions does about abuse' and the complaints process.

Requires Improvement

Is the service responsive?

Our findings

Each person had an individualised weekly plan of activities which was displayed within the service. These primarily consisted of activities within the home such as games or a hand massage. Once a week two of the people were supported, if they agreed, to attend a local day service and one person was supported to visit a relative each week. The relative told us they really enjoyed these visits, but did advise that on occasion, their planned meeting with their family member could not take place as no drivers had been available on the shift. They told us this was frustrating, although not a regular occurrence. There was a sensory area within the home and people were supported to spend time there having relaxation therapy. One person had during the summer enjoyed a boat trip and plans were being made to repeat this. Another person loved cats and staff on occasion took them to a local pet shop or cattery. Arrangements were being made for this person to have a cat as a pet. Staff had needed to advocate strongly for this, as the landlord did not normally allow pets. Staff were working with health and social care professionals to develop activity profiles for people and it was evident that they were also trying a range of different approaches with another person to encourage them to re-engage with attending the day centre and going out for walks with varying success. This person's advocate was positive about the lengths staff were going to adapt their approach. They said, "They are so intent on getting it right…they are constantly trying to problem solve".

However, we did observe, that there were some missed opportunities for staff to interact more with people either during quiet moments or when completing household tasks. For example, we noted that staff did not always share their meal with people and people were not encouraged to get involved in cooking. We felt more could be done to offer people a wider range of activities. For example, twice in one week, one person's planned activity was making a powdered dessert. An action plan from one person's review held in September 2016 was that they be supported to visit an accessible cycling service. This had not yet been tried. It was not clear that alternatives were offered if people chose not to take place in a planned activity such as attending the day centre or going out for a walk or a drive. Staff told us that due to their changing needs, people were now often more reluctant to undertake activities both within and outside of the home. A member of staff told us, "It's hard to find things to do". Another member of staff said, "No there are not enough opportunities, I have suggested swimming for [person], there are risks involved, but it might be worth it".

People seemed to spend long periods of time in bed. A social care professional also commented on this, they said, "It sometimes feels like a very sedentary lifestyle there, the staff are very person centred in places, but I have not seen a lot of evidence of [the person] taking part in activities, it's always chores, rather than a range of activities". This professional told us they had been told that the sedentary lifestyle was 'due to the stage of life the guys were at'. A health care professional told us that the quality of activities and interactions was an area which "Could be greatly improved". They told us, "I have found staff are often in the kitchen with service users, not engaging in one to one activities. They explained that an occupational therapist had produced activity profiles for service users, however they had not seen these being implemented. We spoke with the registered manager about this, they agreed that more could be done to enhance to quality of interactions with people and offer active support. To address this, they were making arrangements for a performance coach to support staff with developing their approach to providing active support. They also

planned to investigate options for sourcing intensive interaction training for staff. We learnt that a staff member was also to be given the lead for reviewing the weekly activities plans to ensure these provided a good balance between the activities staff knew people enjoyed and trying new ones to see if people responded well to these and could therefore be incorporated in to their weekly plan. These planned improvements will need to be embedded and sustained to help ensure that people are provided with every opportunity to engage with a range of interactions they find meaningful and enjoyable.

People's care and support plans were person centred and contained detailed information about their likes and dislikes, their preferred daily routines and the things that made them happy. For example, people's care plans included a 'one page profile' that described, 'How to support me well' and what a good and bad day might look like for the person. The profile also included information about the person's dreams for the future. The profiles listed the person's gifts and skills and the relationships that were important to them. One person's support plan described how it was important to them to visit a relative. We saw that staff were supporting them to do this on a weekly basis. The support plans included information about how people liked their personal care to be provided, the support they needed to eat and drink and the support they needed overnight. One person's support plan had detailed information about how staff should manage their moving and handling needs. This included pictures to help guide staff. The way people communicated was detailed and guidance was available for staff about what people's behaviours might mean. For example, we saw that if one person was biting their hands, this meant that they needed attention. Staff were directed to ensure they were including the person and involving them in an activity. To ensure staff had clear guidance about how people's drinks should be prepared, there was a notice on the kitchen wall recording, 'What I like, How I like it and how I need it' for each person.

There was evidence that as people's needs increased or changed, staff adapted the support provided to ensure it continued to be person centred. For example, staff had put in place a flashing light doorbell for staff to use before entering the room of one person who was hard of hearing. This person also had a vibrating pad and flashing light to alert them that the fire alarm was sounding. Another person had a sensor mat which alarmed when the person experienced an episode of incontinence. This helped to ensure that the person had a restful nights' sleep without the invasive night checks that were leaving them tired throughout the day. Staff told us they could refer to people's care plans in order to understand their needs and it was evident that the care plans had been read by staff. For example, one person's eating and drinking plan noted that they preferred to sit at the end of the table, required the use of an angled spoon and a scooped dish. The staff member supporting them should be on the right side and use a hand over hand technique to assist. We observed that this is how the person was supported to eat their lunch. The detailed support plans helped to ensure staff understood the needs of the people they supported and enabled them to care for them in a person centred manner.

Staff maintained daily logs which noted how the person had been, what they had eaten and what activities they had been involved in. The daily logs could be used to record whether people had enjoyed a specific activity or meal so that the information could inform menu and activity planning. This was of particular importance at Kilford Court as the people being supported were not always able to communicate their preferred meal choices and activities. However, we noted that staff were not always recording this type of information and therefore this limited the ability of the records to be used to fully monitor aspects of the care and support people received. Staff also completed '4+1' meetings which were monthly reviews between the person and their key worker. We also found that these could also be more effectively used to report what had worked well for the person that month allowing those activities or interactions to be built into people's ongoing routines.

Person centred reviews (PCP's) took place and people, their family if involved, advocates and health and

social care professionals were asked to give their views and feedback about the care and support they received. The meetings were used to agree new goals and objectives and actions plans were produced which detailed which staff member would be responsible for supporting the person to achieve the goal. We reviewed the action plan resulting from one person's review. Most of the actions had been completed or were in the process of being completed. For example, the registered manager was taking action to develop links with a learning disability hospital liaison nurse so that plans could be made to reduce the anxiety and distress visits to hospital caused the person. Relatives and professionals told us that staff were good at keeping them informed of any changes to people's needs.

Complaints policies and procedures were in place and were available in easy read formats. There had been three complaints since our last inspection. The complaints had been documented, investigated, acted upon and used to improve the service in accordance with the provider's complaints policy.

Good

Is the service well-led?

Our findings

Our last inspection had highlighted a lack of management resources within the services. Staff felt they needed a clearer sense of direction and others felt that an increased management presence would help them to feel more confident and supported in their role. This inspection found that improvements had been made. The registered manager was now only responsible for managing two services which meant they were able to spend more time within the service. It was evident the registered manager knew people well and understood their individual needs. It was clear that they wanted the best for each person and was committed to taking action where necessary to bring about improvements to their lives. One person's advocate told us, "I am pretty impressed with the new manager, anything I have said, she is on it". A health care professional told us, "The manager has been very co-operative with us and appears to have a good relationship with staff and service users…they have a wealth of information and is able to share this when required".

It was also evident that the registered manager was supportive of the staff team and committed to their personal and skill development. Staff felt more supported and clear about their role and responsibilities, they spoke more positively about the atmosphere with the service and told us morale was much improved. One staff member told us, "We have all had to knuckle down". Another staff member said, "It's a 100% better" and a third, "It seems a cheerful place to work". Staff told us that a lot of the improvements were down to the new registered manager who now been in post eight months. One staff member told us the registered manager was "Really good…I know I can go to her [with any problems] and she will sort it out, morale is growing stronger, it's nice, we can support one another, its better". Another said, "[the registered manager] has been very supportive…it's a lot better, a lot more things are getting done, you feel part of something, it used to be a very negative house, they are very fair…if you say to her, something is not right, she is on to it, for example, she got [person] his wheelchair, she kept going at it until it was sorted…it's a cheerful place to come and work…it's a great team". This was echoed by a third staff member who said, "They [the registered manager] say this is how I want things done, we now know how to work, they are strict but fair, you know where you stand".

Staff meetings were held regularly and were an opportunity for staff and the registered manager to discuss issues affecting the people they supported but also staffing issues such as leave, policy updates and health and safety matters. The last meeting in December 2016 had been used to reflect upon the previous year, what had worked well, what had staff learnt and the issues they had concerns about. A plan had been agreed with staff of the actions needed to continue to drive improvements throughout the coming year. Managers meetings were held. These were an opportunity for the provider's local managers to come together and share ideas, best practice and policy updates. For example, we saw that a recent managers meeting was used to reflect upon how staff might be supported to complete the Care Certificate in a timely way and the obstacles to this. The provider issued 'Core Briefs' for staff with updates on strategic developments and to help ensure they were kept informed of challenges, achievements and known risks within the organisation. The January 2017 core brief was celebrating the success of the #I'mWithSam Campaign. The campaign which was being led by Dimensions is aimed at tackling hate crime aimed at people with learning disabilities and autism.

There were a range of systems in place to assess and monitor the quality and safety of the service and to ensure that people were receiving the best possible support. Medicines were audited weekly by staff and the management team performed monthly medicines spot checks. Checks were made to ensure the safety of people's finances. The provider undertook audits at the service. We reviewed the audit that had taken place in May 2016. This was detailed and aligned to the five key questions that our inspections focus on, allowing judgements to be made as to whether the service was safe, effective, caring, responsive and well led. Local commissioners had undertaken a detailed annual quality assurance audit and an external infection control audit and been completed. The outcome of these audits fed into the service's improvement plan. This detailed the areas where improvements were required, the steps needed to deliver these and a clear time scale for completion, although, we noted that most of the required improvements had already been completed.

Staff completed a range of health and safety checks to help identify any risks or concerns in relation to the environment and equipment used for delivering people's care. Monthly checks were undertaken of the fire alarm system and exits, water temperatures and equipment such as wheelchairs and slings. A fire risk assessment had been completed in June 2016, the actions resulting from this had been completed. People had personal emergency evacuation plans (PEEPS) which detailed the assistance they would require for safe evacuation of their home. A legionella risk assessment had also been completed, although staff were not able to evidence that the ongoing monthly checks recommended in the risk assessment were taking place. We have asked for confirmation of this. We will continue to liaise with the registered manager to obtain this.

The provider's core belief was that people with learning disabilities and experiencing autism should have the same rights and responsibilities as others. To achieve this, the organisation promoted a clear set of values to underpin the support provided to people. These were respect, partnership, courage, integrity and ambition. We saw of examples of these values in action. Staff demonstrated a respect for the people they were caring for and worked in partnership both with them and with other health and social care professionals to enhance aspects of their lives. The registered manager has displayed resilience and courage by continuing to advocate for people using the service in order to enhance their environment, obtain essential equipment and support them to achieve important goals such as getting a pet. The registered manager had advocated with them in a bid to bring about an organisational change in how they support staff who were hearing impaired. People were given the opportunity to voice their opinions about the service and the provider in a variety of ways. For example, staff had supported one person to attend a 'Driving up Quality' event in 2016. This was a national event that listened to what people using Dimensions services thought was going well and where the support provided needed to improve.