Care Quality Commission

Dimensions (UK) Limited

Dimensions Loddon House

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

Overall summary

This was an unannounced inspection which took place on 16 June 2015.

Dimensions- Loddon House is registered to provide care for up to four people. The home provides a service for people with learning and associated behavioural and physical disabilities. There were three people living in the service on the day of the visit. The service had ground and first floor accommodation. The bedrooms do not have en-suite facilities.

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

People were kept as safe as possible. Care workers were trained in and understood how to protect people in their

Summary of findings

care from harm or abuse. Individual and general risks to people were identified and managed appropriately. The home had a stable staff group who had built strong relationships with people who lived there. Staff members had an in-depth knowledge of people and their needs. The staff team were well supported by the registered manager and other senior staff to ensure they were able to offer appropriate, safe care to people.

People were supported and encouraged to look after their health. Care staff were skilled in using people's individual communication methods and in helping them to make as many decisions for themselves as they could. People were supported to be as independent as they were able to be, as safely as possible.

Peoples' rights were recognised and maintained. The service understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. Appropriate DoLS applications were made to the local authority.

People were offered support by caring, kind and patient staff. Staffing ratios meant that people's needs were met and their requests for help or attention were responded to quickly. People were given the opportunity to participate in a variety of individualised activities which they chose and enjoyed. Care staff understood how to maintain and promote people's privacy and dignity and respected them at all times. The individualised care planning ensured people's equality and diversity was respected.

Care staff told us the home was well managed and had an open and positive culture. The registered manager was approachable and staff were confident to discuss any issues with her. The registered manager and staff team made sure that the quality of the service they offered was always maintained and improved when possible.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe.

People were protected from abuse or harm by staff who had received appropriate training and knew people well.

Risks to people, staff or other visitors were identified and action was taken to make sure people were kept as safe as possible.

People were given their medicines safely. They were given the right amount at the right times.

People were given safe care because there were enough staff to meet their needs safely.

Good

Is the service effective?
The service is effective.

People made as many choices and decisions for themselves as they could. Staff understood consent and mental capacity. They made sure people's rights were always considered and maintained.

People's individual health and care needs were met in the best way possible, because staff were properly trained.

The service was 'homely' and comfortable and reflected people's tastes and choices.

Good

Is the service caring?
The service is caring.

People were treated with respect and dignity at all times. Their different needs were recognised and respected. Staff were kind, patient and caring.

People's individual methods of communication were clearly recorded, understood and used by staff to explain what was happening, why and when.

People who did not have family or friends involvement were provided with someone who could make sure they were properly cared for.

Good

Is the service responsive?
The service is responsive

People's needs were responded to quickly by staff members.

People's care was given in the way they preferred and that met their individual needs.

The service worked closely with other professionals, asked them for advice and listened to them.

Staff knew how to interpret people's behaviours which showed if they were concerned or distressed.

The service's complaints procedure was detailed and clearly told staff how to respond to any complaints or concerns.

Good

Summary of findings

Is the service well-led?

Good

The service is well-led.

Staff told us that the registered manager and senior staff team were approachable and open. They said they were confident to discuss any issues with senior staff.

The service regularly checked it was giving good care. The manager and staff maintained and improved the quality of care whenever possible.

Dimensions Loddon House

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 unannounced inspection which took place on 16 June 2015 was completed by one inspector.

Before the inspection we looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at the three care plans, daily notes and other documentation, such as medication records, relating to people who use the service. In addition we looked at quality assurance audit reports, health and safety documentation and a sample of staff records.

We spoke briefly with people who live in the service. We received written comments from one family member and a health professional. Additionally we spoke with two staff members, the assistant locality manager and the registered manager. We looked at all the information held about the three people who live in the service and observed the care they were offered during our visit.

Good

Is the service safe?

Our findings

People were unable to tell us clearly if they felt safe in the service. However, two people were able to nod and indicate by smiling that they felt safe and happy in the home. Staff members and a relative told us people were, ''safe and well treated''.

People were protected from all forms of abuse and were kept safe by staff who were well trained and fully understood their responsibilities in regard to safeguarding. All seven care workers had received safeguarding training. Safeguarding training was repeated every year, to ensure all staff were kept up-to-date with policies and procedures. The home made the local authority's latest safeguarding procedures available to all staff. Staff had a clear understanding of their responsibilities with regard to protecting the people in their care. They were knowledgeable about the signs of abuse and what would constitute a safeguarding concern. They described how they would deal with a safeguarding issue, including reporting issues outside of the organisation, if necessary. Staff were aware of the provider's whistle blowing policy and explained under what circumstances and why they would 'whistle blow'.

People staff and visitors to the home were kept as safe as possible by the service. Generic health and safety risk assessments for areas such as use of bed guards, using wheelchair restraints on the minibus and monitoring water temperatures in baths were in place. Regular health and safety maintenance checks were completed for all relevant areas. Checks such as those for portable equipment, fire alarm systems and gas systems were completed at scheduled intervals as recommended by health and safety policies. A staff member was identified as the health and safety lead. They attended a quarterly health and safety meeting, ensured monthly health and safety check-lists were completed and passed any up-dated information to the rest of the staff team. An emergency evacuation plan was available to staff. The service recorded all accidents and incidents and added them to the provider's computer system every week, as necessary. There had been no incidents or accidents in the previous year.

People's care plans included risk assessments incorporated into support guidelines. These gave staff detailed information about how to support people in a way that minimised risk for the individual and others. Identified areas of risk depended on the individual and included areas such as eating, support at night and fluid intake. A risk management analysis provided staff with an 'easy check' of which risks assessments were in place for people. The service made use of cross referencing from care plans to risk assessments and support guidelines to draw staff's attention to all the necessary information.

People were given their medicines safely by care staff in the team who had been trained to complete this task. Staff's competence in medicines administration was tested every year, by a senior staff member. The service used a monitored dosage system (MDS) to assist them to administer medicines safely. MDS meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MARs) were accurate and showed that people had received the correct amount of medicine at the right times. The temperature of the medicines storage area was recorded on a daily basis and action taken to rectify the temperature, as necessary. People had detailed guidelines for the use of any PRN (to be taken as necessary) medicines and a stock check list of them was kept. A senior staff member audited medicines every week to two weeks. The local pharmacy had carried out their annual audit on 5 December 2014 and recorded no concerns. The service had not recorded any medicines errors since 2013. The locality manager confirmed that there had not been any in that period of time.

People were supported by staff who had been recruited as safely as possible. The service had not recruited any new staff since 2013 when their recruitment records were judged as robust. The provider, currently, used an external organisation who completed the necessary safety checks on prospective applicants. Fully completed application forms and all staff recruitment records would be available to the registered manager, who views them prior to making an appointment. The registered manager told us the new system is used effectively in the other location she manages.

People were supported by appropriate numbers of well trained staff. The minimum staff on duty was two per shift during the day and one sleeping in staff and one awake throughout the night. Numbers of staff were continually monitored by senior staff and additional staff could be used if required. Additional staff were provided for special occasions, activities and to meet the needs of people. The

Good

Is the service safe?

service generally used bank staff to cover staff shortages but if they did need to use agency staff they ensured continuity by asking for staff who had worked in the home before. Agency staff always worked alongside a permanent staff member. Four weeks rotas showed that staffing never dropped below those identified by the service as minimum.

Good

Is the service effective?

Our findings

A family member told us the care their relative received was, ‘‘excellent’’ and that staff, ‘‘are generally without fault’’.

People were supported to make their own decisions and choices, as far as possible. The plans of care included decision making profiles and agreements and noted how people must be involved. Part of the care plan was called, ‘‘How I keep and stay in control’’. They noted what level of decisions people could make and what assistance they needed to make ‘informed’ decisions. The plans described when, how and who could make final decisions on specific areas of care and when formal processes needed to be followed. Best interests meetings had been held and were planned in regard to health procedures.

The registered manager and other staff fully understood issues of consent, mental capacity and DoLS. The registered manager had submitted DoLS applications, appropriately, to the local authority. The seven permanent staff had received Mental capacity Act 2005 and DoLS training. Staff were able to explain what a deprivation of liberty was. They described the action they would take if they were concerned that they had to deprive someone of their rights. One person had been appointed an independent Mental Health Act advocate (IMCA) to ensure their rights were being upheld.

The service took responsibility for people’s personal allowances. Other financial matters were dealt with by families or friends acting as appointees or by an advocate provided by a voluntary group. However, there was some confusion with regard to whether non-family members could act as appointees. The registered manager undertook to clarify who had a legal right to administer people’s finances if people lacked capacity to give permission for others to act on their behalf. The service had a robust system of recording the money they held on behalf of people. The income, expenditure and cash records were accurate.

People’s health needs were identified and assessed. Part of the care plan was called, ‘‘about my health’’. This included the history of people’s health, current health needs and issues, how to prepare people for health related appointments. Additionally people had hospital passports so that hospital staff would know how to offer care, if necessary and detailed medical reports and records were kept. The local authority had a specialist learning disability health service which provided psychiatrists, occupational therapist and other health care professionals. People had regular health and well-being check-ups and were referred to specialist health professionals as necessary.

People were encouraged to eat healthy food as noted in an area of the care plan called, ‘’my meal times’’. People did not have specialist nutritional needs but any areas of concern were risk assessed. For example there was a risk assessment for ‘choking’. Individual guidelines for staff to ensure people were helped to eat their food safely and in the way they responded best to. The service sought the help of speech and language specialists with regard to swallowing difficulties. People contributed to writing menus which were well balanced and included fresh food.

People were provided with any specialist equipment they needed to keep them safe, comfortable and as independent as possible. The building was on two floors but there was, currently, no –one living in the first floor bedroom The home had a ‘homely feel’ and good standard of cleanliness.

People who lived in the home did not have behaviours that could cause distress or harm. The service did not use physical restraint. However, staff could be provided with training and support from the provider’s behaviour management team, if it became necessary.

People were supported by staff who were appropriately trained. Training was delivered by a variety of methods which included computer based and classroom learning. Staff told us they were provided with good opportunities for training. Five of the seven staff had completed the diploma in social care level two training (or above or equivalent).Staff received regular supervision from the registered manager or other senior staff. They told us they could ask for support or advice whenever they needed it. Staff received an appraisal every year and a development plan was written from the outcome of the appraisal. Staff told us that they felt very well supported by the management team.

Good

Is the service caring?

Our findings

People indicated by smiling and nodding that they liked the staff. A relative told us the staff were, ‘‘very caring indeed’’. People were treated with respect and their dignity was preserved at all times. Care staff displayed patience and a caring attitude throughout our visit.

People were helped to maintain relationships with their families or other people who were important to them. Visitors were welcomed to the home and there were no restrictions on times or lengths of visits. The care staff team was stable, with most staff being in post for over two years. They were very knowledgeable about the needs of people and had developed strong relationships with them and their families and friends.

People and their families or advocates attended their annual review meetings and were involved in their care planning, as much as they were able and was appropriate. A relative told us, ‘‘They will discuss with me any concerns they have, they brief me on [name’s] activities and are generally without fault’’.

Information which was relevant to people was produced in differing formats. These included pictures, photographs and symbols. The organisation provided people with a detailed handbook describing the care they could expect to receive, their rights and responsibilities. Information was then explained to individuals in a way which gave them the best opportunity to understand it. Staff followed people’s individual communication plans at all times.

People’s diversity was respected as part of the strong culture of individualised care. People were provided with activities, food and a lifestyle that respected their choices and preferences. Plans of care included a part called, ‘‘getting to know you better’’. This included people’s life choices, aspirations and goals.

People were encouraged to be as independent as they were able. Care plans noted how much people could do or be encouraged to do for themselves. Risk assessments supported people to be as independent as possible. During the inspection staff were interacting positively with people at all times. People were encouraged to express themselves and make as many decisions as they could. They included them in all conversations and described what they were doing and why. People were asked for their permission before care staff undertook any care or other activities.

People’s privacy and dignity was maintained and promoted by care staff. They had received dignity training and understood how to how they supported and assisted people, with sometimes intimate care tasks, without compromising their privacy and dignity. They gave examples of how they did this which included advising people where it was appropriate to disrobe and how they carried out personal care tasks.

Good

Is the service responsive?

Our findings

People's needs were met by care staff who were knowledgeable about the needs of people in their care. There were small numbers of people and high staff ratios to enable staff to respond immediately to people's requests for help or attention. Care staff were able to interpret body language and other forms of communication to identify when people needed assistance.

People had a full assessment of their needs prior to the moving in to the service. They and their families, social workers and other services were involved in the assessment process. The final assessment was completed by a senior staff member from the service. A care plan was written and agreed with individuals and other interested parties, as appropriate. Care plans were reviewed by the key worker when necessary and a formal review was held at least once a year. The review included information such as 'what people like and admire about me', 'what is important to me' and 'what is important for the future for me'.

People were offered very individualised care. Staff were trained in person centred care and were able to demonstrate their understanding of what this meant. They told us, ''each individual is different and needs different types of support with what they need and different types of help to achieve what they want' 'Another staff member described how they built strong relationships with people and tried to ensure consistency of care so that people were confident to express their needs and preferences.

People's individualised care plans included sections called, 'my personal information', 'a good day', 'a bad day' and 'support wanted and needed'. They clearly described the person, their tastes, and preferences and how they wanted to be supported. The roles and responsibilities of the person and the staff members were recorded on care plans. The skills and training staff needed to offer the required support were noted and provided, as necessary.

People's activities plans were developed to meet the needs, preferences and abilities of the individual. The activities were included in the part of the care plan entitled, ''my perfect week' 'Whilst activities were planned in advance the activity programme was flexible to respond to people's choices and needs 'on the day'. A variety of activities were provided including outings into the community, pub visits and in-house hobbies and activities.

Information was provided to try to ensure people knew how to make a complaint or raise a concern. It was provided for individuals in a way that they may be able to understand. Care staff were aware that people would need assistance to make a complaint. They described how they would interpret body language and other communication methods to gauge if people were unhappy. There was a complaints procedure displayed in the office and in communal areas of the home. Complaints and concerns formed part of the service's and provider's quality auditing processes and were recorded on a computer programme, when received. No complaints had been recorded by the service in the previous two years, the registered manager confirmed that no complaints had been received in that time frame.

Good

Is the service well-led?

Our findings

Staff described the registered manager as, ‘‘approachable’’ and the service as having an, ‘‘open and positive culture’’. Another staff member said they felt, ‘’valued and part of a strong open team’’. Staff members told us they were very comfortable to discuss any issues or matters with the registered manager. Staff supervisions included a ‘’360 degree’’ review. For this review the supervisor sought the views of people who use the service, colleagues, people’s families, and other professionals to ensure the quality of staff performance. Staff told us this contributed to the culture of openness in the service. Managers told us this was a major contributor to the overall quality of care offered to people.

The registered manager is called the locality manager. She is registered to manage two residential services. Staff told us that although she was always available she had no pattern of being in the service. The assistant unit manager, who was generally in day to day control of the service, was also beginning to spend some days each week in another service. Staff told us they were much more comfortable when the registered manager was in the service regularly. Additionally they were concerned that the assistant unit manager was not in the service for all of their hours. The management arrangements were causing some anxiety in the staff team.

Staff meetings were held regularly. The last one was held 5 May 2015. Minutes showed discussions included person centred ‘tools’, health and safety and ‘what’s working what’s not’. . The local authority and the provider’s quality and compliance audit team sent through bulletins and information about new developments in the care field such as the new Health and Social Care Act regulations.

People were offered good quality care. A relative described the care over a number of years as, ‘‘excellent’’. The service did not hold resident meetings but recorded what people liked and disliked about their daily lives by interpreting their body language. Care staff told us that people were more likely to express their view on a one to one basis than in a meeting. There were a variety of reviewing and monitoring systems to ensure the quality of care was maintained and improved. The provider’s representative completed a quality assurance inspection every three months. This covered all areas of the functioning of the service. After each inspection a service improvement plan was written by the registered manager. It noted what and why actions were to be taken, who was responsible for taking them and by when.

The registered manager and assistant unit manager told us they had the authority to make decisions to ensure the safety and comfort of the people who live in the home. Examples included accessing additional staff and ordering emergency repairs, as necessary.

The service worked closely with health and social care professionals to achieve the best care for the people they supported. They had strong links with the specialist community learning disability health team. People’s needs were accurately reflected in detailed plans of care and risk assessments. Records relating to other aspects of the running of the home such as audit records and health and safety maintenance records were accurate and up-to-date.