

Dimensions (UK) Limited

Dimensions Fountain House Innox Lane

Inspection report

Fountain House
Innox Lane, Upper Swainswick
Bath
Avon
BA1 8DD

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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

Dimensions Fountain House is registered to provide accommodation for up to eight people who require personal care. At the time of our inspection there were seven people living at the service. The people who live at the service have learning disabilities and profound physical needs.

At the last inspection, the service was rated Good.

At this inspection we found the service remained Good.

Why the service is rated good:

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Risks to people were assessed and where required a risk management plan was in place to support people manage an identified risk and keep them safe.

Staffing numbers were sufficient to meet people's needs and this ensured people were supported safely. People's representatives told us that they were satisfied about their relative's safety.

People received effective support from staff that had the skills and knowledge to meet their needs. The provider ensured that new staff completed an induction training programme which prepared them for their role. Staff received on-going training to enable them to fulfil the requirements of the role.

Staff were supported through a supervision programme. Supervision is where staff meet one to one with their line manager to discuss their work and development.

People were supported to maintain good health and had access to external health care professionals when required.

Staff were caring towards people and there was a good relationship between people and staff. Staff demonstrated an understanding of the needs and preferences of the people they cared for.

Support provided to people met their needs. Supporting records highlighted information about what was important to people and how to support them. People were involved in activities of their choice.

There were systems in place to assess, monitor and improve the quality and safety of the service. To ensure continuous improvement the provider had a service improvement in place. This provided actions required within set timelines.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service remains Good.

Is the service effective?

Good ●

The service remains Good.

Is the service caring?

Good ●

The service remains Good.

Is the service responsive?

Good ●

The service remains Good.

Is the service well-led?

Good ●

The service remains Good.

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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 checked 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 comprehensive inspection took place on 29 October 2017. The inspection was announced, which meant the provider knew we would be visiting. This is because we wanted to make sure the provider, or someone who could act on their behalf, would be available to support the inspection. This inspection was carried out by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with four members of staff, the deputy and registered manager. Following our visit to the service we spoke with two relatives of people. The people who used the service were unable to tell us of their experience of living in the house. We observed interactions between staff in communal areas.

We looked at three people's care and support plans and medicine administration records. We also looked at records relating to the management of the service such as the daily communication records, audits, supervision and training records.

Is the service safe?

Our findings

People's relatives felt the service provided a safe environment. One relative told us; "She's safe. I have no concerns about her safety."

Staffing numbers were sufficient to meet people's needs and this ensured people were supported safely. Staff we spoke with felt the staffing level was manageable. Staffing rotas demonstrated that the staffing levels were maintained in accordance with the dependency needs of the people who lived at the service. We observed that there were sufficient staff to help people when needed, such as assisting at mealtimes, medicine administration and taking people out. Three staff had recently left and the service are currently trying to recruit new staff team members. Comments from staff and people's representatives regarding staffing levels; "At the moment it's ok. The aim is to have four support workers as a minimum and that is always maintained"; "Staffing levels are satisfactory but could be better. There are no less than four. We have just lost three staff"; "I think they're enough staff"; and "Staffing levels are fine."

Recruitment procedures ensured all pre-employment requirements were completed before new staff were appointed and commenced their employment. An enhanced Disclosure and Barring Service (DBS) check had been completed. The DBS check ensured that people barred from working with certain groups such as vulnerable adults would be identified.

Staff demonstrated a good understanding of abuse and knew the correct action to take if they were concerned about a person being at risk. Staff had received training in safeguarding adults. Staff told us they felt confident to speak directly with the deputy and registered manager. They told us they would be listened to. Staff were aware that they could report their concerns to external authorities, such as the local authority and the Commission.

People were cared for in a safe, clean and hygienic environment. The rooms throughout the service were well-maintained. Environmental checks had been undertaken regularly to help ensure the premises were safe. These included, fire safety, water and building maintenance.

Risks to people were assessed and where required a risk management plan was in place to manage an identified risk and keep the person safe. These included assessments for the person's specific needs such as managing epilepsy, personal care, finance, moving and handling, use of vehicle and oxygen therapy. Assessments were reviewed regularly and updated, when required. Within the person's records, appropriate support and guidance for staff was recorded. When speaking to staff they demonstrated a clear understanding of the control measures required for people's specific risks, such as actions required if people have epileptic seizures. This ensured that persons' risks were effectively managed.

People were receiving their medicines in line with their prescriptions. Medicine Administration Records (MARs) were used to record the administration of medicines. Of the sample that we viewed, we saw that these were completed accurately. Staff had received training in medication. PRN protocols were in place for each person. The term PRN is given to a medication which is to be taken 'when required' and is usually

prescribed to treat short term or intermittent medical conditions and not to be taken regularly. Some people were receiving their medicines covertly. This is when medicines are disguised within food or drink. Arrangements for giving medicines covertly complied with the requirements of the Mental Capacity Act (MCA) 2005. Capacity assessments were conducted and best interest meetings were held with relevant parties, such as health professionals, staff and the persons' representatives.

Medicines were stored in a lockable medicines cupboard to ensure that they could not be accessed by anyone who was not authorised to do so. Stock checks of all medicines were undertaken and these had been clearly documented. Regular medicine audits were undertaken and actions were taken, where required. This included the recommendation by the external pharmacist audit to ensure that the temperature of the medicines storage room is recorded daily.

Arrangements were in place for reporting and reviewing accidents and incidents. This included auditing all incidents to identify any particular trend or lessons to be learned. Accident and incident forms identified the nature of the incident, immediate actions taken and whether any further actions were required. An example of this included further staff medicine competency assessments being conducted, following an incident where a medicine had been found by a member of staff and not administered.

Environmental checks had been undertaken regularly to help ensure the premises were safe. These included water, electrical and equipment checks. The provider ensured that premises and any equipment provided in connection with fire-fighting, fire detection and warning or emergency routes and exits were covered by a suitable system of maintenance by a competent person. Contingency plans were in place in case the service needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation.

Is the service effective?

Our findings

People's rights were being upheld in line with the Mental Capacity Act 2005. This is a legal framework to protect people who are unable to make certain decisions themselves. We saw information in peoples' support plans about mental capacity and Deprivation of Liberty Safeguards (DoLS). DoLS applications had been applied for appropriately. These safeguards aim to protect people living in homes from being inappropriately deprived of their liberty. These safeguards can only be used when a person lacks the mental capacity to make certain decisions and there is no other way of supporting the person safely.

Staff completed Mental Capacity Act 2005 (MCA) training and understood the importance of promoting choice and empowerment to people when supporting them. Where possible the service enabled people to make their own decisions and assist the decision making process where they could. Each member of staff we spoke with placed emphasis on enabling the people they assisted to make their own choices, as far as possible. They were trained in understanding each person's non-verbal communication methods. For one person we were told; "Although [person's name] is not able to tell you what food he wants he is very capable of letting you know what food he doesn't want. He loves to smell touch the food before it is cooked." Another staff member told us; "For [person's name] you offer options and she will let you know preferences. She will push you away if she doesn't like anything."

People received effective support from staff that had the skills and knowledge to meet their needs. The provider ensured that new staff completed an induction training programme which prepared them for their role. Staff received on-going training to enable them to fulfil the requirements of the role. We reviewed the training records which showed training was completed in key aspects of care to ensure staff and people at the service were safe. Additional training specific to the needs of people who used the service had been provided for staff, such as epilepsy awareness training.

Staff were supported through a supervision programme. Supervision is where staff meet one to one with their line manager. Conducting regular supervisions ensured that staff competence levels were maintained to the expected standard and training needs were acted upon.

People's nutrition and hydration needs were met. Appropriate professional advice had been sought regarding specific dietary requirements, such as textured diets. Each person had mealtime placement guidance in place for staff to follow. This included positioning, equipment and assistance required. Staff demonstrated a detailed knowledge of each person's nutrition and hydration needs.

People were supported to maintain good health and had access to external health care professionals when required. We saw people had received input from the GP, mental health team, speech and language therapist and epilepsy nurse. The service had recently arranged a visit for one person from a physiotherapist. Their aim was to implement a trial of a new sleep system and sitting posture.

Is the service caring?

Our findings

People's representatives spoke positively about the staff and the support they provided. Comments included; "My general impression is that it's very good. [Person's name] is very happy. The staff are lovely and sufficiently trained. She's not always the best tempered and they know her moods. They have evolved with her. Her needs are met"; and "By and large she gets good care. The staff are diligent and work hard. It really is a very good place. Communication is not always brilliant." One health professional had recently complimented the service for being "homely."

People were supported by a small committed team. Our observations showed that good relationships had been established between staff and the people they provided care for. During the lunchtime service one staff member was singing to the Sound of Music playing in the lounge. People appeared to appreciate their efforts. Staff were laughing and engaging with people. People were eating together. One person was enjoying playing with their sensory equipment whilst waiting for their lunch. One member of staff was comforting a person by stroking their arm. There was lots of eye contact, positive interactions and engagement with people. Staff did not rush people during their meal. One person liked to play and throw their toy on the floor and staff were laughing with them. Where one person was becoming distressed they were moved to a quiet area and staff reassured them.

Staff demonstrated they had a good understanding of people's individual needs and understood people's preferences. One member of staff provided examples of how people preferred to be supported; "[Person's name] can get quite tense and sometimes he grabs my finger. He knows I'm his friend. I rub his back and sometimes that works to make him less tense. [Person's name] will make a clucking noise when she wants something. She's always so cheerful. When you support her in the bath, she can get upset. You talk through things and provide reassurance and use familiar things. [Person's name] is like a lovable rogue. He has a propensity to scream but it is his way of having banter. He likes a joke and is jovial. He likes his food but you have to be very patient. When he gets agitated, you have to adopt a process of elimination. He likes his bath and the sensory room. He likes to be on the move and try different things."

Staff spoke about people in a meaningful way and took an active interest in what people were doing. Staff offered support to people with their plans throughout the day. One member of staff had decorated the sensory room and we saw it was used by people throughout the day.

People were provided with activities, food and a lifestyle that respected their cultural needs, choices and preferences. People kept their own personal belongings where they wished to and had their rooms furnished to their own individual taste. The provider had added a family room to the service. The room is decorated with artwork created by people, staff and relatives. Staff respected people's privacy. People were able to have time alone and their personal space was respected. We observed that one person particularly like spending time in the music room and staff would check on them periodically to ensure they were still content staying in that area. Staff respected people's dignity. When providing personal care a 'Bathroom in use' sign was displayed.

The staff team have recently been nominated by the provider as an Inspiring team. They have been recognised for making an outstanding contribution in accordance with the provider's vision, mission and values, and for making a real difference in helping the people they support to live the life they choose.

Is the service responsive?

Our findings

The service was responsive to people's needs. Their needs were met by staff who worked together to offer the best care they could. People received good care that was personal to them and staff assisted them with the things they made the choices to do. We observed that people appeared content living in the service and they received the support they required. Staff comments included; "We support people to be out in the community. It's a home, its homely"; "Everyone is well-looked after and well-supported. The staff back each other up. We respect each other"; and "I think we're quite ambitious. We look into and try different thing. The support workers are good."

A care plan was written and agreed with individuals and people's representatives as appropriate. Care plans were reviewed regularly and a formal review was held once a year and if people's care needs changed. Issues discussed included; "What's important to me now?"; "What's important to me in the future?"; "What support do I need to stay healthy and safe?"; "What's Working?"; "What's not working?"; and "What are the questions and issues to resolve and how are we going to resolve these issues?" Staff responded to any issues identified by the person by amending plans of care, updating chosen goals and support required. For one person this included enabling visits to their local mosque and arranging for an Imam to visit, enabling family visits and the provision of further sensory stimulation. Another person had recently been diagnosed with a serious medical condition. Discussions were held with family members regarding the person's quality of life and what they feel the person would want. It was agree that the person would be referred to a palliative care team for on-going support. A family member told us about their involvement in the decision making process. They told us they were currently in the process of writing to the service to progress matters. They were anxious to implement the agreed plans and for the service to be proactive to progress their relative's on-going support.

Care records were personalised and described how people preferred to be supported. Specific personal care needs and preferred routines were identified. One person had a dual sensory impairment. Each member of staff had their own method of approach to enable the person to establish who is communicating with them. One method was wearing the same perfume so the person could identify them. People's individual needs were recorded and specific personalised information was documented. Each person's care plan included personal profiles, which included what was important to the person and how best to support them. Staff all had an in-depth knowledge of the people they supported and had the confidence to enable the people they support. One member of staff told us; "Ideas are incorporated where possible. Some people tried ice-skating as they were wheel chair friendly at the venue. We've tried specially adapted bicycles. [Person's name] enjoyed it immensely."

People undertook activities personal to them. Activities included hydrotherapy, swimming, music therapy, shopping, attending a day centre, going out to eat, bowling and cinema visits. One family member told us; "[Person's name] loves going out to eat, being out and about and doing things. She goes out shopping with staff, they're lovely." Where appropriate people were encouraged to maintain contact with their family and were therefore not isolated from those people closest to them.

Each person held a hospital passport in their records. The passport is designed to help people communicate their needs to doctors, nurses and other professionals. It includes things hospital staff must know about the person such as medical history and allergies. It also identifies things are important to the person such as how to communicate with them and their likes and dislikes.

The provider had systems in place to receive and monitor any complaints that were made. The service had not received any formal complaints in 2017. People were not able to complain without assistance and they would need the support of staff or families to make a complaint. Staff described how they would interpret body language and other communication methods to ascertain if people were unhappy. Family members advised that they would feel confident to approach the registered manager if they had any concerns.

Is the service well-led?

Our findings

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.'

All services registered with the Commission must notify the Commission about certain changes, events and incidents affecting their service or the people who use it. Notifications tell us about significant events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service made appropriate notifications to the Commission.

We received mixed comments from staff and people about the management team included; "[Registered manager's name] and [Deputy Manager's name] are very approachable. They treat me fairly and helped me develop. They have an open door policy. We have monthly staff meetings. I think we're listened to"; "[Deputy Manager's name] is great. She says 'grab me if you need me.' I not so sure about the registered manager"; "[Deputy Manager's name] is fantastic, terrific man-management. I feel listened to. One person has recently left because they didn't get on with the registered manager"; and "Communication is not always brilliant. Staff are leaving as they did not feel listened to and that is down to the management."

The registered manager has recently written to staff advising them of their 'Fish philosophy' initiative. They have issued staff with permission slips to complete if they feel that the registered manager has gone off track or upset them in any way. The registered manager advised that it is giving staff to opportunity to "call them out." The registered manager advised staff that they will review the slips to see how or what they can do to try and sort things out either with themselves or the service. Owing to the philosophy being at its preliminary stages at the service it was too early to assess any actions taken as a result of staff comments.

The registered manager has also been part of a work experience drive for health and social care students and they have had volunteers from the local college working to gain knowledge and skills with the provider's services. Future planned initiative includes the set-up of a social enterprise scheme within the grounds. Their goal with the assistance of local college students is to grow their own produce and look at keeping some chickens.

Regular team meetings were held to discuss operational issues and people's needs. Items discussed at every team meeting included the five principles of the Mental Capacity Act, the five domains of a CQC inspection, the provider's newsletter, medication, health and safety and policy directives. Communication books were in place for the staff team. We saw that staff detailed the necessary information such as healthcare appointments and new staff guidance specific to the person's needs. This meant that staff had all the appropriate information at staff handover.

People and their relatives were encouraged to provide their views and were actively involved in the decision-making process, such as the choice of activities and future goals. One family member told us; "I know the

content of the care plan and have attended meetings. They always ask me and seek my feedback."

To ensure continuous improvement the provider conducted regular quality and compliance review. They reviewed the key lines of enquiry addressed at a CQC inspection. The observations identified compliant practice and areas where improvements were required, such as the need for staff to complete mandatory training. We found this action had been taken forward.