Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Dimensions 22 Mill Croft

22 Mill Croft, Scunthorpe, DN16 1QL

Tel: 01724869489

Date of Inspection: 10 July 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Dimensions (UK) Limited
Registered Manager	Mrs. Kirsty Davies
Overview of the service	22 Millcroft is a purpose built single storey home for up to six people with a learning disability. It is situated in a residential setting and close to local facilities. The home has six single bedrooms, a bathroom, a kitchen, a laundry and a large lounge/dining room. There is a garden at the rear of the property and car parking at the front.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 July 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with carers and / or family members, talked with staff and talked with commissioners of services.

What people told us and what we found

We found people were involved as much as possible in decisions about care and treatment. Decisions were made in people's best interest when they were assessed as not having capacity to make the decision. We observed staff speak with people in a caring and friendly way.

People who used the service were provided with a balanced and varied diet. We found staff were knowledgeable about people's nutritional needs and health professionals provided guidance and treatment when required.

We found people received their medicines as prescribed.

We found there were sufficient staff employed in the service to meet people's needs. Relatives said staff kept them informed about important issues and they had observed staff treat people with dignity and respect. Comments included, "The staff are great, you can talk to them" and "They are lovely and really seem to understand her. The staff are calm and don't flap. I trust them completely."

The service had a complaints procedure and people who used the service were provided with information in a format that was appropriate for them. Relatives told us they knew how to complain and would feel able to complain if required.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

During the inspection we used a number of different methods to help us understand the experiences of people who used the service because the people who used the service had complex needs which meant they were not able to tell us their experience. We spoke with the manager and two support workers. We also spoke with a performance officer from the local authority review team and we spoke with the local safeguarding team. We contacted two relatives and had conversations with them over the phone. We looked at records and we observed how staff spoke to people and provided care and support to them.

We found that before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We observed staff providing explanations to people and asking them what they wanted to do rather than telling them what they must do. We observed people making their own decisions. For example where they wanted to sit and what they wanted to eat.

The registered manager told us people who used the service were able to make day to day decisions themselves. They said staff knew people's needs and preferences very well and used non-verbal communication methods to establish decisions about day to day care and support. This was confirmed in discussions with staff and observations of practice.

A relative we spoke with told us they were invited to meetings to discuss progress, care and support provided to their relative.

We looked at the care records of two people who used the service. These contained records such as assessments, care plans, instructions from health professionals and discussions held with GPs and family regarding care. These showed us that people were involved in decisions about their care and treatment as much as possible.

We saw staff had completed assessments to establish if people had the capacity to make specific decisions. For example, attendance at routine medical appointments, surgical

procedures and the use of a lap strap in a wheelchair which would restrict movement. Meetings had been held with relevant people in attendance to discuss what decisions were to be made in the person's best interest. This showed us where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

In discussions, staff were aware of the basic principles of the Mental Capacity Act 2005 (MCA). One member of staff said, "You don't assume people haven't got capacity to make their own decisions" and "You have to have best interest meetings to discuss and decide things." Training records indicated all staff had completed training in MCA and deprivation of liberty safeguards although we were unable to see when this had occurred.

We spoke with a performance officer from the local authority quality and review team. They told us a visit to the service had found mental capacity assessments and best interest decisions were in place. They also found that consultation had been completed regarding payment and use of the service's minibus. They told us they were involved in annual reviews of the care of the people who used the service.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We found people were provided with a choice of suitable and nutritious food and drink. We observed people were supported to be able to eat and drink sufficient amounts to meet their needs.

People who used the service had assessments and plans of care for their nutritional needs. The care plans identified risks such as choking and what actions staff had to take to minimise the risks. The records gave staff guidance in how to meet people's needs which included, preferences, likes, dislikes, the type and consistency of food required and the level of staff support. They also detailed which aids were required to promote independence such as plate guards and clothes protectors. We saw the care plans reminded staff to offer choice and alternatives and they detailed how people communicated their needs.

In discussions, it was clear staff knew people's likes and dislikes. They described how the weekly menu was devised by talking to people who used the service, showing them pictures of meals and referring to their likes and dislikes list. Staff told us they had completed training in nutrition and basic food hygiene. They were knowledgeable about what constituted a balanced diet but were mindful that treats remained a part of the menu.

We observed the lunchtime experience for people who used the service. People sat together at the dining room table and staff provided varying levels of support. For example, one person was able to eat their meal independently when their food was cut up into bite sized pieces and a plate guard was used. Two people required full support from staff. Both staff sat next to people and encouraged independence where possible. For example, one staff was observed using hand over hand support to direct the spoon to the person's mouth. Support was sensitive and appropriate and people seemed to enjoy their meal.

Staff told us they had no concerns about the budget for food shopping. They planned menus and shopped twice a week. One person who used the service liked to complete the shopping tasks with staff. We saw that menus were varied and alternatives were available. Fresh fruit and vegetables were prepared each day.

Staff monitored and recorded people's weight and referred to health professionals such as GPs, dieticians and speech and language therapists when required. They also recorded the food and fluid people ate and drank each day. In this way they were able to monitor

nutritional intake and add to people's lists of likes and dislikes.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We found appropriate arrangements were in place in relation to obtaining, recording and administering medicines. We found that medicines were kept safely and were returned to the pharmacy when no longer required.

During the inspection we spent time in the staff office were medicines were stored. Staff recorded the temperature of the room to monitor that medicines were stored at the correct temperature. The provider may find it useful to note that the temperature of the room regularly rose above that which was recommended for the storage of medicines by manufacturers. Staff had used measures such as opening the window and office door and used a fan to cool the room but these measures were not consistently successful. We found the rise in temperature had only recently occurred due to the spell of hot weather. The manager was to seek advice from the local pharmacy and also discuss with senior managers.

It was noted that the service did not have a controlled drugs (CD) cupboard. Currently there were no people who used the service who were prescribed CDs but as this could change, it was mentioned to the manager to assess whether one was required.

We looked at the medication administration records (MARs) for all four people who used the service. We found that medicines were signed when received into the home and when they were given to people. There were systems in place to ensure people did not run out of their medicines and when staff needed to return unused medicines to the pharmacy. There were also protocols in place to guide staff in the administration of medicines which were prescribed to be taken when required. We found one protocol had recently been reviewed and updated so that the medicine could be reduced. We found some staff had not been made aware of the update. We spoke with staff later in the day and they told us they had been made aware of the changes.

We found staff received training in the management of medicines and also completed competency tests every six months or more frequently as required. Audits of medicines were completed and there was evidence that issues had been raised for the manager to address with staff.

Care plans were in place to guide staff in how to support people who used the service with their medicines. There was also an information sheet held with the MAR which detailed how people took their medicines, for example one said the person took their medicines from a medicine pot and another said they may prefer to have their medicines placed on top of jam or yoghurt. There was correspondence from the GP confirming that staff were able to administer medicines in this way.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. We looked at staff rotas and they indicated there were always two staff on duty during the day to support the four people who used the service. Night support consisted of one member of staff and an additional member of staff who completed a sleep-in duty. We found there were additional staff on duty during the day four days a week in order for people who used the service to complete visits to local facilities in the community. This included, shopping, visiting pubs and cafes, swimming, walking and attending church.

There was a manager on duty five days a week who managed three small services all in close proximity to each other. There were also two assistant managers to oversee the three services. They ensured days were set aside each week to complete administration tasks such as staff supervision and auditing records.

Staff we spoke with confirmed the information in the rotas and said there were sufficient staff on duty to meet the current needs of people who used the service. Whilst on duty during the day and night, staff completed domestic and catering tasks. Some of these were completed with people who used the service to encourage and promote independence, for example, laundry, shopping and preparing meals. Staff told us it was important for people who used the service to participate in activities in daily living. They said the involvement ranged from observing staff complete tasks to participating in other ways such as carrying laundry to the washing machine whilst sitting in their wheelchair.

We observed staff treat people with kindness and we overheard staff speak to people in a caring and friendly way.

Relatives we spoke with were complimentary about staff. They said staff kept them informed about important issues and they had observed staff treat people with dignity and respect. Comments included, "The staff are great, you can talk to them. They are more like friends and they don't mind us asking things", "They definitely seemed skilled and I am glad we have found a place like this" and "They are lovely and really seem to understand her. The staff are calm and don't flap. I trust them completely."

Training records showed us staff had access to a range of training appropriate to their role.

Staff confirmed they completed training and said they received regular supervision. They described the manager as supportive and said they could speak to them directly if they had any concerns.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

The service had a complaints policy and procedure that detailed timescales for acknowledgement and investigation. The complaints procedure was available in easy read format and we found these had been placed in each person's care file. This showed us people were made aware of the complaints system and it was provided in a format that met their needs.

Staff had a flow chart to guide them in how to manage complaints. There were also complaints forms to complete which detailed the nature of the complaint, findings from investigation and any action required. All staff had signed to say they had read and understood the complaints procedure.

Relatives we spoke with told us they knew how to complain and said they would feel able to complain to staff or the manager. One relative told us they had raised some issues with the staff and these had been resolved.

We found the service had very few complaints. Staff we spoke with were mindful that the people who used the service would be unable to complain verbally. Staff told us they observed people closely and knew when they were unhappy and chose not to do things. We observed that care records detailed people's preferences, likes and dislikes. Staff told us that knowledge of people's needs and adherence to care plans helped to prevent people from being dissatisfied with their care. We saw minutes of meetings attended by staff and people who used the service. These showed us staff tried to obtain people's views and checked they were happy with the care provided.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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