Dimensions (UK) Limited

Dimensions 4 Matlock Close

Inspection report

4 Matlock Close
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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

Our inspection of Dimensions 4 Matlock Close took place on 17 and 21 August 2018. This was an unannounced inspection.

Dimensions 4 Matlock Close is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates eight people in a large, purpose built bungalow. At the time of our inspection there were no vacancies. The people living at the home had learning disabilities and a range of other needs such as autism, physical impairments and complex health needs.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

The home had a registered manager. A registered manager is a person who has registered with CQC 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 living at the home were protected from the risk of harm or abuse. Staff members had received training in safeguarding adults and demonstrated an understanding of their roles and responsibilities in ensuring people were safe. Detailed and person-centred risk assessments had been developed which included guidance for staff members on the management and minimisation of risks.

The home had developed person centred care plans for people. These were detailed and included guidance for staff on meeting people's need and choices in accordance with their preferences. However, some care plans had not been updated to reflect changes in people's needs and social activities. In addition, some daily care notes had not been fully completed. This meant that we could not be sure if people always received the support they required.

People's medicines were managed and administered to them safely. Medicines administration records were appropriately completed and regular audits of records and stocks of medicines had been undertaken. Staff members had received training in safe administration of medicines and their competency in doing so had been assessed.

The staff records that we viewed showed that the provider had carried out checks to ensure that staff were of good character and suitable to work at the home. New staff members received an induction which

included the completion of the Care Certificate which provides a set of nationally recognised standards for staff working in health and social care services. All staff were required to undertake a range of mandatory training courses to ensure that they were competent in supporting people. Additional training courses associated with the specific needs of people had also been provided.

During our inspection we observed that staff members supported people in a gentle, kind and respectful way. People appeared familiar and comfortable with the staff who were supporting them. The staff members we spoke with were knowledgeable about people's needs and preferences.

Staff members supported people living at the home to participate in a wide range of activities. These included meals out, theatre and cinema visits and music and craft sessions. People had also been supported to take annual holidays. Some people also attended a local day centre on a regular basis. Arrangements had been put in place to ensure that staff understood how to ensure that people's specific cultural needs were met, along with other needs and preferences.

The home was meeting the requirements of the Mental Capacity Act (MCA) 2005. People's capacity to make decisions had been assessed and Deprivation of Liberty (DoLS) authorisations had been sought and obtained from the local authority. DoLS authorisations are required where people lack capacity to make decisions to ensure that any restrictions put in place for their safety are legal and in their best interests.

The provider and registered manager undertook regular quality assurance monitoring and audits. The outcomes of these were shared with staff members at team meetings and any required actions were addressed. Although we found that there were failures in relation to the quality of some care plans and daily notes, these had been identified and action was underway to address them. However, at the time of our inspection there remained the need for further action in relation to these failures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People had up to date risk assessments which included guidance for staff on the avoidance and management of risk.

Staff members had received training in safeguarding adults and understood their roles and responsibilities in relation to keeping people safe from harm and abuse.

Medicines were well managed and given to people safely.

Is the service effective?

Good

The service was effective. Staff members had received training and supervision to support them in carrying out their duties.

The service was meeting the requirements of the Mental Capacity Act (2005).

People were supported to eat a healthy diet. Individual dietary needs in relation to culture and health were supported.

Is the service caring?

Good

The service was caring. Staff members supported people in a kind and respectful way. People were familiar and comfortable with staff members.

People's privacy was respected.

Staff members communicated with people using a range of methods and understood people's non-verbal communication.

Is the service responsive?

Requires Improvement

The service was not always responsive. Some care plans had not been updated to reflect changes in people's needs. Daily records of care had not always been fully completed.

People were supported to participate in a wide range of activities at the home and in the wider community.

The service had a complaints procedure. A family member told us that they knew how to make a complaint if required.

Is the service well-led?

Good

The service was well-led. Failures in the care plans and the daily care records had been identified and action to address this was in progress.

Regular monitoring of the quality of records and care had taken place.

Staff members spoke positively about the support they had received from the management team.

Dimensions 4 Matlock Close

Detailed findings

Background to this inspection

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

This inspection took place on 17 and 21 August 2018 and was unannounced. The inspection was carried out by a single inspector.

Before the inspection the provider had completed a Provider Information Record (PIR). This is a form that asks the provider for key information about the service, what the service does well, and what improvements they plan to make. We also reviewed our records about the service, including previous inspection reports, enquiries and regulatory notifications of incidents which are required to be provided to CQC.

During our visit we met six people who lived at the home. Because the majority of people living at the home had communication impairments, we were unable to fully assess their views of the care and support that they received. However, we were able to obtain limited feedback from one person. We were able to spend time observing care and support being delivered in the communal areas, including interactions between staff members and people who used the service. We also spoke with two family members of a person who lived at the home. In addition, we spoke with the registered manager, the assistant manager and three members of the care team. We looked at records, which included the care records for three people who lived at the home, four staff recruitment records, policies and procedures, medicines records, and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People living at the home were unable to tell us if they felt safe. Family members told us, "I wouldn't let [relative] live here if they weren't safe," and, "They are really good at making sure that [relative] stays well and safe."

People who lived at the home were protected from identified risks associated with day to day living and wellbeing. Their risk assessments were personalised and had been completed for a range of areas including people's behaviours, anxieties, personal care activities, eating and drinking and health and mobility needs. Situational risk assessments were in place for a wide range of activities both inside the home and within the local community. We saw that these were up to date and had been reviewed on a regular basis. Risk management plans were detailed and included step by step guidance for staff around how they should manage identified risks, for example, risk management plans for people with epilepsy included information on how to recognise the signs of the type of seizure that the person experienced and what action to take. Risk assessments for people who occasionally demonstrated behaviours that could be challenging to others also contained guidance for staff. This included information about the identification and avoidance of possible 'triggers'. People's risk management plans included guidance on the use of sensitive approaches to identify and minimise behaviours at an early stage to reduce the likelihood of risk. We saw that, where appropriate, staff at the home had liaised with other health professionals to develop guidance in relation to reducing risk to people.

People's risk assessments and management plans were regularly updated and staff members were required to sign to show that they had read the most recent versions. We noted that some recently updated risk assessments were in the home's 'read and sign folder' for staff but copies had not yet been placed in people's care and support files. We discussed this with the registered manager who told us that they would ensure that people's files were updated to include copies of these assessments.

Medicines prescribed for people living at the home were safely managed and stored. People's medicines administration records (MARs) were appropriately completed and signed. We observed that staff signed the MARs after people's medicines had been taken by them. A controlled medicine had been prescribed for one person and administration of this was also recorded in a controlled drugs register in accordance with the requirements of the Misuse of Drugs Regulations (2001). Stock counts of controlled medicines took place after they were given to the person and the register was signed by two members of staff. This showed that the provider was meeting the requirements of the Misuse of Drugs Regulations.

All staff members at the home had received training in the safe administration of medicines. We saw that checks of their competency in this area had also taken place. Information and guidance in relation to supporting people to take their medicines safely was contained within their risk assessments and support plans. For example, detailed guidance was in place for administering medicines through a PEG tube. A PEG tube is a form of gastronomy feeding where nutrition, fluids and medicines are provided to people unable to take nutrition or medicines orally by means of a tube inserted into the stomach.

Regular audits of medicines stocks and records were also in place. Daily counts of medicines took place at the time of staff handovers at shift changes. Regular monthly management audits of medicine stocks and MAR charts had also taken place.

People living at the home were unable to tell us if they felt safe. Family members told us, "I wouldn't let [relative] live here if they weren't safe," and, "They are really good at making sure that [relative] stays well and safe."

The staff members we spoke with understood the importance of ensuring that people were kept safe from the risk of harm or abuse. All staff members working at the home had received training in safeguarding of adults, and we saw that this had been regularly 'refreshed. Staff were knowledgeable about their roles in ensuring that people were safe and could demonstrate an understanding of how to recognise and report any suspicion of abuse. We reviewed the safeguarding records and history for the home and saw that safeguarding concerns had been reported and managed appropriately.

The home looked after people's monies for day to day expenditure. We saw that records of these were well maintained, receipted, and that these matched people's cash balances. The provider used a secure system for ensuring that people's monies were maintained safely. Money was contained within bags sealed by numbered disks. Whenever a person's money was accessed by staff, a balance was recorded, along with the number of the new disk used to reseal the bag People's records showed that checks of monies took place at 'handover' at the beginning and end of each staff shift. Monthly monitoring of financial records had taken place, and monies maintained at the home were reconciled against people's bank statements. We also saw evidence that the provider undertook a formal annual audit of people's finances.

We saw from the staffing rotas and our observations of staff supporting people during our inspection that the provider had made appropriate arrangements to ensure that people received the support that they required, and that there was continuity of care from a stable staff team. The staff members we spoke with told us that there enough staff members on shift at any time to ensure that people were supported. One staff member said, "Sometimes it gets a bit stressful but we all support each other."

We looked at four staff files and these showed us that the provider had arrangements in place to ensure that they recruited staff who were suitable to work with the people whom they supported. Staff recruitment records included copies of identification documents, evidence of eligibility to work in the UK, two written references, application forms and criminal record checks. Detailed policies and procedures were in place in relation to staff recruitment and the staffing records showed that these had been followed.

The home environment was suitable for the needs of the people who lived there. The communal areas were spacious and that there was sufficient space for people to move around safely. Regular health and safety audits of the building had taken place. These included action plans where improvements were required and we saw that identified actions had been addressed in a timely manner. Records showed that safety checks at the home, for example, in relation to gas, electricity, fire equipment and portable electrical appliances were up to date.

Accident and incident information was appropriately recorded. Staff members described emergency procedures at the home, and we saw evidence that fire drills and fire safety checks took place regularly. People's risk assessments included information about fire and other emergency evacuations. A 'grab and go' bag was maintained which contained essential information should an emergency evacuation of the home take place.

The provider maintained an out of hours emergency contact service, information about which was clearly displayed on the office wall. The staff members that we spoke with were aware of this and how to use it.

Good

Is the service effective?

Our findings

A family member told us, "[Relative] is really well supported here. I can't fault them really."

All staff members at the home had received mandatory training, such as safeguarding, infection control, manual handling, epilepsy awareness and medicines awareness. Additional training that related to people's specific needs was also provided, for example, in understanding learning disabilities, and positive behavioural approaches. Training was refreshed on a regular basis, and we saw that the provider maintained an on-line training matrix that alerted staff members and the registered manager if any training was due. The staff members that we spoke with spoke positively about the training that they received which was delivered through a mix of on-line and classroom based sessions. All new staff received induction training which met the standards of the Care Certificate for staff working in social care services. The staff members we spoke with told us that they thought that the training they had received was good. One staff member said, "The training helps to remind me and make me think about what I am doing."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Policies and procedures were in place in relation to the Mental Capacity Act (MCA) 2005. These were consistent with the MCA Code of Practice for health and social care providers. Staff had received training in the MCA 2005 and demonstrated that they were aware of the key principles of the Act. Applications had been made to the local authority for Deprivation of Liberty Safeguards (DoLS) to be put in place for people who lived at the home to ensure that they were not unduly restricted. We saw that DoLS authorisations were up to date. People's care records also showed that, where they were unable to make decisions about specific activities or interventions, best interests decision meetings had taken place. These included, for example, decisions in relation to holidays and healthcare treatments. The records of these meetings showed that input from family members and key health and social care professionals had been sought.

People's care plans provided guidance for staff members in relation to supporting them to make decisions about their daily activities and care. During our inspection we observed that staff members used a range of methods, including words, signs, pictures and objects to support people to make decisions. Where people were unable to participate in the process of developing their care plans, a form was in place which showed how the plans had been developed using knowledge and experience of people's preferences.

During our inspection we observed two mealtimes. We saw that staff members offered choices to people in relation to what they would like to eat and drink in ways that they understood. People could eat their meals where they wished. For example, we saw that some people preferred to eat at the kitchen table and others sat at a preferred place in the dining room. People were encouraged to eat independently where possible, and we saw, for example, that specialist equipment such as plate guards and cutlery had been obtained to assist them with this. Where staff supported people to eat, we observed that they gave people time to eat and spoke with them in a sensitive way throughout the mealtime. Personalised information about people's dietary needs was displayed in the kitchen. This included details of people's cultural and health needs and preferences.

Staff at the home followed effective food safety practices, including safe storage of food items and the monitoring of temperatures of fridges and freezers and of hot foods. Following our inspection the service achieved a rating of rating of four (good) as a result of a food safety inspection.

There were effective working relationships with relevant health care professionals. We saw that regular appointments were in place, for example, with challenging behaviour services, as well as the GP and dentist. Staff members accompanying people to appointments had completed a record of what had been discussed and agreed at these. Care plans included information about people's health needs and guidance in relation to the support that they required to maintain their health and wellbeing. Individualised hospital passports had been developed for people at the home. These included information about people's healthcare needs and prescribed medicines along with detailed guidance in relation to their communication and support needs and individual preferences. The registered manager told us that the home was in the process of developing health action plans for people using a model provided by the commissioning local authority.

People's families were involved in their care and their feedback was sought regarding the care provided to their relatives. A family member said that "They are very good at keeping me informed."

Good

Is the service caring?

Our findings

A family member spoke positively about the care that their relative received. They told us, "Although we have had ups and downs, the staff generally have a good attitude to making sure [relative] is well looked after."

People were supported by staff members who treated them with dignity and respect. We saw that care was delivered in a sensitive manner, and was flexible in ensuring that people were given the time that they needed for activities. Staff members were gentle and positive in their communications and people appeared relaxed and comfortable with the workers who were supporting them. We saw that staff members were familiar with the people they supported, and spoke with them about the things that were meaningful to them. We observed friendly interactions between people who used the service and their care staff who used words and signs that people understood, and we saw that people responded positively to this. For example, when we observed staff communicating with people with significant communication impairments. It was clear from people's responses that they understood what staff members were trying to tell them. Staff members checked that they understood people's responses, and we observed people smiling and physically indicating that they had been understood.

Staff members at the home had been trained in 'Active Support'. This is a method of supporting people with learning disabilities to engage with daily living activities. The assistant manager had also been trained in 'Intensive Interaction' which provides a means of developing communication with people with autism and severe and profound learning disabilities. The weekly activity plan for a person showed that intensive interaction sessions were taking place on a regular basis. During our inspection we used intensive interaction methods to develop communication with this person and we saw that they responded positively to this. The registered manager told us that the service intended to ensure that all staff members received intensive interaction training in the near future.

The service was sensitive to people's cultural, religious and personal relationship needs. We saw that information about people's religious, cultural and personal needs and interests were recorded in their care plans. Cultural and religious dietary requirements were clearly recorded and the staff members we spoke with were aware of these. The registered manager told us that people were supported by staff to attend places of worship if they wished. We saw that information about this was included in their care plans. We asked the registered manager if people had expressed preferences in relation to their personal relationships. They told us that this was not currently the case, but that staff at the home would be required to support people to develop and maintain any personal relationships should they wish.

The registered manager told us that people could access advocacy services if required, and we saw that information about local advocacy services was available at the service. However, people had very strong links with their families who were fully involved in their care. Family members maintained regular contact with their relatives and we saw that regular home visits were included in people's activity plans.

Although most people living at the home were unable to communicate verbally, staff members told us that

they were involved as much as possible in decisions about their care. A staff member told us, "We get to know how they show that they are happy or unhappy with things. This helps us work out how we can support them in the way that they want." We saw that care plans included information about people's likes and dislikes, along with guidance for staff on their communication needs and preferences. The plans included information on 'what works' and 'what doesn't' for each person, and the staff members that we spoke with demonstrated that they were familiar with this guidance.

Requires Improvement

Is the service responsive?

Our findings

People's needs were regularly assessed and reviewed. A family member said, "They keep me involved and they always try to make sure that [my relative] understands everything."

People had detailed care plans which contained guidance for staff in relation to meeting people's identified needs. The care plans were clearly laid out and written in plain English with some picture assisted information. The registered manager told us that video assisted information was being developed in relation to people's support needs and daily activities and we were shown an example of this. They said that people responded well to photographs and videos and this was being developed as a means of enabling people to engage with their care plans. There was a clear link to people's assessments and other information contained within their files. Although people were unable to be actively involved in developing their plans, the home recorded how these were developed using staff and family member's knowledge of each person's needs and preferences along with input from other professionals.

The care plans that we viewed detailed people's personal history, their spiritual and cultural needs, health needs, likes and dislikes, preferred activities, and information about the people who were important to them. Information about people's communication needs and preferences and the management of behaviours and anxieties was clearly recorded. For example, a plan in relation to a person's anxieties described signs of distress, along with information about 'triggers' to be avoided where possible. These were supported with clear stage-by stage information to reduce levels of arousal and enable staff members to support the person to manage their behaviours in a positive way. One staff member told us, "The care plans are very important. They show us how to support people in the best way we can."

However, we found that some people's care plans had not been updated to reflect their current situation. One person's plan did not reflect changes in their daily activities. Three people's care plans identified objectives with dates for achieving these during 2017. These dates had passed, but there was no record of whether these objectives had been achieved. The registered manager told us that the objectives had been met and that people's plans would be updated to reflect this.

Records of daily care and support were in place, but these were variable in quality. For example, the records for a person who required regular repositioning did not show if this had taken place which meant that there was no evidence that staff had taken action to ensure that the person's physical health needs were fully met. The failures to ensure that care plans and records of care were up to date and fully completed meant that we could not be sure that people always received the care and support that they required.

We spoke with the registered manager and assistant manager about this. The assistant manager showed us copies of care plans that had recently been updated in a revised format. She told us that the outstanding care plans were in the process of being reviewed and revised. The registered manager also told us that a new online system for recording daily care records was in the process of being introduced. The system will require staff members to record all daily care and support activities on a tablet. The system will provide alerts for staff and management if any record is not fully completed.

Information about people's communication needs was detailed and contained clear guidance for staff members on how to ensure that people were enabled to communicate their needs effectively. For example, there was information about how people communicated their needs, and how staff should respond to this communication using signs, pictures and objects of reference. During our inspection, we observed staff members communicating with people, and we saw that they used a range of methods described in their care plans. We saw, for example, that pictures of meals were provided to people to support them to make choices.

People's care documents included individual activity plans and we saw that they participated in a range of activities within the local community that included shopping, walks and meals out. Some people attended a local day centre on a number of days each week. During our inspection we spent time observing a session provided by a musician who visited the home on a weekly basis. People were supported to be fully engaged and two staff members joined in, singing and dancing with the music and checking that people were enjoying the activity. We also saw that people were supported to go out to a local café for a meal.

We were shown photographs of activities which had taken place at the home, including a range of celebrations of cultural festivities. People had also been supported to go to shows and other events based on their interests. Records of activities, including how people were supported were completed regularly for each person.

The home had a complaints procedure that was available in an easy read format. A family member that we spoke with confirmed that they knew how to raise any complaints or concerns. They told us that, "I know how to complain but I don't have any complaints."

Good

Is the service well-led?

Our findings

A family member told us, "The manager is very good. They listen and sort things out for [relative]."

The registered manager was supported by an assistant manager and a senior support worker. During our inspection we saw that the registered manager and assistant manager spent time engaging with people and staff members. They demonstrated that they were familiar with people's needs and we observed a relaxed and easy relationship between them and people living at the home who appeared comfortable when they were around.

The staff members that we spoke with told us that they felt that the manager and assistant manager were supportive and approachable. They also spoke highly of the support that they received from the provider. One staff member told us, "I am very happy with the management." Another said, "the management here are very supportive." We saw that the manager and assistant manager spent time with staff members and people who used the service, and that their interactions were positive and informal. Staff members told us that a member of the management team was always available if they needed any guidance or support.

Staff members had job descriptions which identified their role and who they were responsible to. The staff members that we spoke with were clear about their roles and responsibilities in ensuring that the people who used the service were well supported.

Minutes of regular staff team meetings showed that there were regular opportunities for discussion about quality issues and people's support needs. The assistant manager told us that urgent information was communicated to staff immediately. We saw recorded evidence of this, which included the communications book and 'handover' meeting records, and the staff members that we spoke with confirmed that this was the case. We observed a shift handover session and noted that 'need to know' information was clearly communicated to staff members who were working on the next shift.

There were systems in place to monitor the quality of the home and we saw evidence that monthly safety and quality reviews had taken place. The records of the provider's quarterly internal compliance audits showed that detailed monitoring of a range of quality issues had taken place. These included monitoring of records, recruitment, medicines, monies, health and safety, and community engagement. They also showed that observations of staff support and engagement were monitored. Actions required as a result of these audits were amalgamated into a service improvement plan. We looked at the most recent plan, and noted that these showed clear evidence of how and when actions had been addressed.

The management team had also undertaken regular weekly and monthly monitoring, for example, in relation to medicines, finances, health and safety and records. The registered manager and assistant manager had identified that some people's care plans required updating and that there were gaps in people's daily care records. We saw that actions had commenced to address these issues. However, these had not been completed at the time of our inspection.

We reviewed the policies and procedures.in place at the home. These were up to date and reflected good practice guidance. There was a process in place to ensure that staff members were required to sign when they had read the policies.

Records maintained by the home showed that the provider worked with partners such as health and social care professionals to ensure that people received the services that they required. Information regarding appointments, meetings and visits with such professionals was recorded in people's care files.