Dimensions (UK) Limited

Dimensions London Domiciliary Care Office

Inspection report

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12 October 2018

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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

This inspection took place between 8 and 12 October 2018 and was announced.

At our last inspection in February 2016 we rated the service Good. At this inspection we found evidence continued to support the rating of Good.

There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

This service provides care and support to people living in 'supported living' settings, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

At the time of this inspection the service was providing personal care and support to 88 people living in their own homes. The majority of these people lived in a supported living scheme in a shared house or flat.

The registered manager was supported by locality managers who managed between three and four supported living schemes each.

The service also provided a specialist service providing Applied Behaviour Analysis and positive behaviour support for people with an autistic spectrum condition to develop their life skills and independence. These people had structured teaching and support programmes delivered by a suitably qualified team.

Staff understood how to safeguard people and risks were managed effectively to help people keep safe and protect their rights.

There were some minor concerns about medicines recording which the registered manager addressed when we brought these to their attention and put steps in place to prevent recurrences.

The service offered "active support" and worked with, rather than for, people they supported. People played an active role in planning their lives and in their day to day routines. People were supported to have maximum choice and control of their lives and the service supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had choice around what they ate, whether they cooked their own meals or had their meals cooked by staff and how they spent their time.

The service provided support to people to maintain good health and with managing health conditions.

People had good support to maintain their independence and their right to privacy was respected. The service helped people with maintaining relationships with their families and friends.

People were involved in planning their care. The service ensured care plans were person centred and updated as and when people's care needs changed.

Effective systems were in place to manage complaints. People using the service and their relatives told us they were happy with the service. The service was person-centred and inclusive.

The service maintained records of care and support provided, people's health needs and wellbeing.

The registered manager had strong leadership skills and introduced new initiatives and ideas to improve opportunities for people. Staff felt well supported by the managers.

The provider was continually improving the service and worked in partnership with health and social care professionals to ensure people's health and social care needs were met. The provider had a comprehensive quality monitoring process. We have made one recommendation about improving the follow up action to the existing quality monitoring processes to ensure improvements are made without delay when needed.

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 remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service has improved to outstanding.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service has deteoriated to good.	**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 inspection was undertaken on 8, 9, 10 ,11 and 12 October 2018. We gave the provider three days' notice that we would be visiting their head office. We gave the provider notice as we wanted to make sure the registered manager would be available for the inspection.

The inspection visit was carried out by three inspectors, two assistant inspectors and two experts by experience. We visited head office and three supported living schemes. The schemes were where people who had a learning disability lived in shared houses or flats. The assistant inspectors made telephone calls to staff and the experts by experience made telephone calls to relatives of people who used the service. Experts by experience are people who have used or care for someone who has sued this type of service.
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Before the inspection, we asked the provider to complete 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. We reviewed the completed PIR and previous inspection reports before the inspection. We also reviewed other information we had about the provider, including notifications of any significant events, safeguarding alerts and feedback from the public about the service.

On the first day of the inspection we met with the registered manager and looked at records in the office. We spoke with seven people who used the service and met another seven people who were not able to talk with us. We spent time with those people and observed their interactions with staff and their daily routines to check on their wellbeing.

We read the care records for 13 people. We read their support plans, risk assessments and all records relating to the care and support they received. We spoke with 11 relatives of people who received support from Dimensions.

We read four staff files to check on the provider's recruitment process. We looked at staff training, supervisions and appraisals. We read other records in the schemes and some that the registered manager emailed to us after the inspection. These were quality monitoring records for two schemes, medicines records, audits, complaints, accidents and incidents, safeguarding investigations, activity records and health and safety records.

Good

Is the service safe?

Our findings

The provider ensured staff were trained in how to respond to any allegations of abuse. Staff had a good understanding of how to safeguard people and the procedures to follow in the event of abuse. Staff also understood the provider's whistleblowing policy and told us they would report any concerns about poor care to the local authority or CQC if necessary.

There had been some safeguarding concerns since the last inspection in 2016. We reviewed these and found the provider had responded appropriately to protect the person in each case. Where staff had not provided safe care the provider had taken appropriate action.

Staff carried out a risk assessment for each person which determined which areas of risk they needed detailed risk assessments for. The risk assessments gave clear guidance to staff on how to support the person to minimise the risk to their safety. At the same time staff supported people to make their own decisions where they could do so. Risk assessments addressed risk such as going out, finances and choking. The provider had a list of "never events" which were things they told people should never happen to them. This included choking on food and being injured by unsafe equipment.

People told us they felt safe where they lived. Someone using a wheelchair confirmed staff always helped them do their belt up. Another person who was unsteady on their feet said there was enough to hold onto around the scheme and so there had been "no accidents." People told us staff did safety checks around the schemes, and we saw monthly records confirming this.

Although two of the three schemes were short on permanent staff, there were enough staff on duty in the three schemes to meet people's needs as agency staff were used. Staff rotas were flexible so that staff worked at the times people needed support. In one home the fire risk assessment recommended two staff on duty at night but the rota showed there was only one staff sleeping in the home on duty at night. We discussed this with the registered manager who told us that this was a recommendation but not required and had assessed that people were safe at night with only one staff. We have requested written confirmation of this. At the time of writing this report this had not yet been received.

The provider offered incentives to staff to help them retain their staff. These included financial incentives, paying toward driving lessons for staff willing to then drive for work and free cinema tickets.

The provider was also improving their recruitment practices and used a values-based recruitment process to try and attract the right people. Recruitment records for staff showed that the required checks of their suitability were in place. This included a criminal records check, proof of identity, health check and references from previous employers.

People received their medicines as prescribed. We found some concerns with recording of medicines in one scheme. One person had a patch prescribed every three days and staff had not recorded on medicines administration records that they had changed the patch for the person even though the number of patches

left indicated that the person had received their patch as prescribed. We noted the patch was given after two days on two occasions across the previous eight days. The deputy explained this may have been due to patch coming off in the shower, however, there was no record of explanation. This demonstrated incomplete records relating to the service's care of the person.

A few people did not have written guidance on when they might need "as needed" medicines such as for indigestion, pain or anxiety. This put people at risk of receiving these medicines too often or not enough if they were not clearly able to say when they needed them. We brought these medicines concerns to the attention of the management team who addressed them quickly after the inspection.

Staff had completed training in administering medicines and had their competency assessed each year. The provider supported the STOMP campaign. STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines. It is a national project involving many different organisations which are helping to stop the overuse of these medicines. STOMP is about helping people to stay well and have a good quality of life. Staff had supported people using this service to have medicines reviews by questioning the prescribers and some had reduced this type of medicines as a result which was very positive.

All staff completed infection control training to minimise the risk of infection being spread in the supported living schemes. The staff handbook guided staff providing personal care to use personal protective equipment and have short nails.

Fire safety was a regular topic in monthly residents' meetings in one scheme. There were up-to-date personal fire evacuation plans for each person.

The registered manager could give examples of learning from when things went wrong. Accidents and incidents were reviewed a senior level to identify any trends and to ensure action was taken to prevent recurrences.

Good

Is the service effective?

Our findings

The service assessed people's needs and ensured these were written into a detailed "Getting to know you better" document and support plan. These contained all the important information for staff to be able to provide effective care and support to people, for example "what is important to me", what makes a good or bad day, perfect week etc. The provider used an outcomes focussed model of support called "Activate." They ran workshops for staff on this approach to care and support.

The service worked to the principles of "Active Support" which was designed to make sure that people had chance to be fully involved in their lives and receive the right range and levels of support to be successful.

The service provided staff with appropriate training to carry out their roles effectively. Staff told us they found the training helpful. The staff providing specialist support were all trained in Applied Behaviour Analysis and positive behaviour support. There was support for staff to complete training and auditory training was available for dyslexic staff if they preferred this method. All staff had regular supervision with a team leader or locality manager to discuss their work and development and annual appraisals.

People received good support with their eating and drinking. They chose what they wanted to eat. One person had their drinking monitored as they were recommended to drink a certain amount daily. This had not always been added up to check the total amount they had drunk and there was no record of any action taken if they had not drunk the recommended amount. This was addressed on the day of the inspection when we raised it. Staff supporting people who had a percutaneous endoscopic gastrostomy (PEG) which meant they were fed by tube directly into their stomach were trained to do so.

Relatives were satisfied with the support people had with eating and drinking. One relative told us; "Initially, my son had started to lose weight because he has a restricted diet, we flagged this up. Now there is a plan to monitor everything that he eats and how much he is eating." Other comments were; "My relative is well fed and looked after" and," My relative gets to eat whatever he wants and the staff support that." They also said staff helped people to maintain a healthy weight. One relative said," I think the staff do help my relative maintain "the right weight" they take my relative for walks, goes to the gym, has a personal trainer, and has a variety of activities which include cycling. The staff do a lot with my relative" and, Yes, they do watch my relatives weight, they are very hot on that."

The service worked in partnership with people's families, local authorities who paid for their services and professionals involved in people's care. Where staff were concerned about a person they referred them for specialist support from professionals such as speech and language therapy and dietitians.. The service supported people well with their health. People had Health Action Plans which detailed all their health needs and hospital passports which contained essential information about their health if they needed to go into hospital.

One of the locality managers was working on a GP awareness programme. They visited GP practices to advise on how to provide effective care for people who have a learning disability.

Relatives were satisfied with the support with health. Comments included; "Regarding appointments, Carers will take them but parents heavily input to the care. We make sure appointments are kept and made" and, "Staff are keen on physical health."

The registered manager told us that they were working on guidelines for staff to recognise and prevent common medical conditions (urinary tract infections and dental concerns) with the aim of reducing hospital admissions for people.

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 with appropriate legal authority. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of
Protection with the support of the person's local authority care team. We checked whether the service was working within the principles of the MCA. We found we had not received any notifications from this service regarding the 88 people they were providing a service to having DoLS in place. The registered manager said there were 75 DoLS in process of being authorised and that they would be notifying us of all DoLS authorised shortly after the inspection.

The service had a policy of assessing people's capacity in a decision specific way. We saw examples of best interest decisions in place for two people buying a car to share and for a person to have a medical procedure. The service used independent advocates for this process if necessary. There was no written record that people had consented to their care plan. The registered manager advised that people new to the service had a "Your support agreement" which they consented to and that this was in the process of being introduced for all people the service supported.

We saw all staff asking for people's consent before providing support to them and asking them what they wanted. We saw people's refusal to do what staff asked them to do was respected and staff behaved in a thoughtful way and took time to try to explain to people what they wanted them to do and why if the request was for safety reasons. In other circumstances staff supported the person to do what they wanted.

Good

Is the service caring?

Our findings

People told us they liked the staff, describing them as 'helpful.' One person said, "Staff make sure we're happy." Another told us, "Staff treat me very well" and "I can talk to the staff if I'm upset."

Relatives were very positive when asked whether staff treated people with kindness and respect. Relatives told us; "The staff are absolutely amazing, there's not one thing I can say bad about them", "I am more than satisfied, my relative is treated like a queen", "We find without exception that the staff are totally caring" and, "I think they do a brilliant job; they are very kind and caring."

Staff provided people with emotional support. One staff member told us, "First, if I see she is a bit anxious or does not look happy I try to communicate with her always telling her everything will be ok. I notice her feelings and what she wants, she has her way to communicate I always try to calm her down and make her day better by involving things she likes."

The service supported people with their relationships with relatives and friends including facilitating visits and keeping relatives up to date with how people were.
There was detailed written information about people's communication so that new staff could understand what people were telling them in the case of people who had no verbal language. We saw active support in progress and people were fully involved in all aspects of their day. This included what they wanted to eat and do. The management team told us people using the service had been involved in meeting potential new staff and being asked what they thought of them so they were actively involved in recruitment of staff.

The provider had good accessible information for people about their policies and events, except for support plans which weren't in an accessible format for most people and did not show their involvement, though managers told us they wrote the plan in conjunction with people and those who could speak for them. Some people had video care plans which was a positive initiative.

Staff told us they took time to encourage independence and to teach people skills they needed. They gave us examples of teaching a person to move their own wheelchair, a person making their own drink, being involved in doing their own laundry and practising using a walking frame to maintain their mobility. The specialist service devised structured teaching skills programmes to help people learn behaviours and skills that would improve their quality of life such as learning to follow safety instructions from staff, road safety and to reduce harmful behaviours.

People told us they could do things for themselves and that staff helped them. One person showed us their room which they had decorated with help of staff. Another person said, "Staff are helpful at getting me dressed." Other people told us that staff helped them to go out, to buy new clothes and to keep their glasses clean. We saw that people made decisions for themselves and had control over their lives. For example, one person went to open the door when the doorbell rung, which staff supervised. Another person was scheduled to go out for the evening but chose not to as they wished to relax and staff respected their choice.

The service bought equipment that enabled people to be as independent as possible, for example kettles that poured without lifting and knives that cut food without cutting skin. We saw these items in use in the schemes and people who would not be able to make their own tea with a standard kettle were now able to do so.
People told us they had keys to their rooms and that staff gave them privacy. We saw staff respecting people's dignity. During our observations all interactions staff had with people in the three schemes was positive, respectful and kind. Staff supported people to make their own choices and decisions in their day to day routines.

Good

Is the service responsive?

Our findings

The provider had templates for support plans which were person centred. People's support needs and their wishes were recorded and there was detailed guidance for staff to follow to meet their needs. Support plans included people's history, current needs and wishes and future goals.

One relative said they thought staff should use more initiative to support activities further afield and one said that there was not enough engagement and meaningful activity where the person lived. Others said that they thought people had a good active lifestyle. One relative said, "He has a very busy schedule of activities every day including Saturday and Sunday when he goes horse riding." People told us they had birthday parties and enjoyed their social lives. Activities people enjoyed included; visiting friends, social clubs, swimming, horse riding, cinema, dance classes, drives, shopping and walking.

People had good support with their religion. One relative told us, "The staff take my relative to the temple, in my religion we have one or two religious festivals and the staff support that very much." One staff member told us how they supported a person to attend synagogue weekly and supported a person to buy Kosher food.

There was an equalities and diversity newsletter for staff and people using the service. This included information on cultural festivals. The service consulted with people's families to find out their cultural and religious requirements. Staff said they respected people's diverse needs.

The service had supported people to get passports so they could travel abroad if they wished. The provider had a campaign which encouraged people to register to vote.

There was good behaviour support service including 24 hours on call service if staff needed advice regarding positive behaviour support.

The provider had oversight of all complaints in the service so they could check suitable responses were made in a timely way. The complaints procedure was available in an easy read format so people knew how to raise concerns.

Relatives said they felt able to raise concerns with the locality manager and the registered manager. One told us, ""I do voice my opinions with what's working and not working, sometimes I might not be correct but the staff explains why I'm not correct sometimes. " Another relative said, "We always feel comfortable to raise any issues and when we do they are addressed." Another told us, "Initially communication wasn't that good, staff didn't keep the house clean, so we had regular meetings and phone call. Then we had fortnightly, now things are better and we have monthly meetings."

The service supported people at the end of their lives where this was needed. They had worked in conjunction with healthcare professionals.

Good

Is the service well-led?

Our findings

There was a registered manager in place. 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. The registered manager for this service managed a number of locality managers and was an operations director for the provider.

The provider had a framework for monitoring quality but this did not always affect improvement in a timely way. There was a quality and compliance team who carried out reviews of each service. These reviews were like CQC inspections, gave each scheme a rating and set out clearly what was working well and what improvements were necessary. The locality managers then were expected to produce a service improvement plan which addressed any areas for improvement. We looked at two of these. The system for making and monitoring improvements was not consistently effective. In one scheme there had been nine requirements for improvement in August 2017 and two were not yet completed. Medicines audits had not found the concerns we found about a medicine not being recorded for six months and a decision about a change of dose recommendation not being recorded. The registered manager addressed these issues immediately when we raised them and improved the audit records that staff were expected to use.

There was a centralised system for updating fire risk assessments. One fire risk assessment was dated January 2017 and the action plan in it was not completed. Two fire doors didn't safely close as stated in the action plan. Records showed no professional checks of the fire system or extinguishers at the scheme since 8 May 2017, despite there being a quarterly frequency in the housing association's fire contract. The management team informed us, after checking with the housing association, that there was no professional check since then, and so a visit would now occur between 21 October and 24 November 2018.The checking was not the provider's responsibility but they did not have an effective system for raising this with the housing association. The internal health and safety checks had not identified the fire doors had not been repaired or that a person with epilepsy had an uncovered radiator in their room.

In another scheme some actions, for example, arranging for a bed to be serviced, had taken one year to act on. The provider had advised that finances checks were not adequate and we found there was no record of what the manager had checked in their finance checks. A health and safety check had recorded that bedrails were in good order when the bedrails were damaged and there had been no management medicines audits carried out since 2016. We spoke with another locality manager who did effective medicines audits weekly. The quality monitoring systems had been dependent on individual managers rather than prescribed by the provider.

We recommend that the provider review their quality and risk monitoring processes to ensure improvements are made in line with best practice.

There was a positive person-centred culture in the organisation which was evidenced through the provider's policies and practices. People who had a learning disability were employed to carry out quality monitoring

of services and the provider worked to an ethos that people should be fully involved in their lives. The provider was involved in national projects advocating the rights of people with learning disabilities such as STOMP, GP awareness and encouraging people to use their right to vote.

There was good management support. There were suitable on call arrangements for staff where they could call a manager 24 hours a day. New managers had a buddy who was a more experienced manager who could support them. The registered manager had monthly meetings with locality managers.

Staff gave positive feedback about their line managers. One said, "I have worked many places in the past but I have never met a manager like [xxxx], she's professional, the way she cares for people we support, everything is in order and of a standard. She's amazing." Other staff said they felt supported and received regular feedback about their work. Managers worked as team supporting each other. They said there was good career progression for staff with appropriate training and development. The provider had staff incentive benefits e.g. paying towards driving lessons for staff who were willing to drive for work purposes, ride your bike to work scheme and free cinema tickets. There was an annual "working together for change" event where the provider gave awards to individual staff and teams for outstanding performance.

The registered manager had good consultation with relatives as individuals and as groups who acted in an advisory role.

The provider effectively consulted people who used the service and staff. There was an "Everybody counts" event held quarterly for people they support who wanted to attend, to discuss issues relevant to them and there was a Critical friend group of friends and family of people using the service that met every quarter. Some schemes held family meetings and others met with families individually where appropriate to do so. People confirmed that 'house meetings' took place regularly. One person said, "We talk about almost anything." Records showed monthly meetings that reminded people of fire and safety matters, and discussion of menus and activities. The registered manager visited the schemes regularly and knew people's names. A relative and staff member told us that the provider asked for their views through regular surveys.

Staff told us of good management support and teamwork within the scheme. One staff member told us they could approach more experienced staff if they were unsure of anything, and that the team "discusses what's working well and what to improve on." Another commented positively on the scheme having a "structured routine, so you know exactly what you're doing each day." We saw clear shift plans being used.

The provider held a "Working together for change" annual event which included celebration of outstanding support workers and teams, providing information and giving opportunity of staff and people using the service to meet the executive team.

The registered manager was available for staff and families to contact and held a regular staff forum where they shared important information.

The management team told us of learning from previous CQC inspections. For example, overdue professional checks recently highlighted at an inspection had resulted in trialling a system of reminding services of when each check was due. The aim was to roll this out across all the provider's services, to be "learning for all" not just at one service. The registered manager developed a managers' workbook listing tasks each locality manager was responsible for. This was just being introduced at the time of the inspection.

The provider analysed data from incidents and safeguarding alerts to identify trends and shared learning

with staff.

The service worked in partnership with families of people using the service. local authorities and other professionals. The registered manager told us about a new service they were setting up and the consultation and assessment process was a good example of collaborative working for the benefit of the people involved. The provider was working jointly with Mencap on a scheme to provide legal advice to people challenging local authorities. The registered manager talked at provider forums about personalisation and how to move from care homes to supported living.