

Dimensions (UK) Limited

# Dimensions South West Counties Domiciliary Care Office

## Inspection report

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20 June 2018

21 June 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

Dimensions South West Counties Care Office provides personal care and support to people with learning disabilities. The organisation manages services provided to people across five counties from the registered office location. At the time of our inspection services were being provided to 108 people who lived in their own homes, either alone or in shared houses with support.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and 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.

The care service had 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." Registering the Right Support CQC policy.

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

People living at the service said they felt safe. Staff knew how to protect people from harm and abuse. Risk assessments had been completed and when risks had been identified, care plans provided clear guidance for staff on how to reduce the risks. Medicines were managed safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Staff said they were trained and supported in their roles. People were supported to have enough to eat and drink.

Care plans were person centred and detailed. Health action plans were in place. We saw examples of staff providing additional levels of support, such as staying with people when they were in hospital. The service had received positive feedback from people and their families. We observed many positive interactions between staff and people. Staff spoke passionately about their roles.

There were robust quality assurance systems in place. Staff spoke highly of the management team and management values. The provider's values were embedded in the day to day support of people. The service met all the relevant fundamental standards.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

<b>Is the service safe?</b> The service remains safe.	<b>Good</b> ●
<b>Is the service effective?</b> The service remains effective.	<b>Good</b> ●
<b>Is the service caring?</b> The service remains caring.	<b>Good</b> ●
<b>Is the service responsive?</b> The service remains responsive.	<b>Good</b> ●
<b>Is the service well-led?</b> The service remains well led.	<b>Good</b> ●

# Dimensions South West Counties Domiciliary Care Office

## **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 was a comprehensive inspection. The inspection took place on 18, 19, 20 and 21 June 2018 and was announced. We gave the service three days notice that we would be coming as we needed to make arrangements for visiting and speaking with people. The inspection was carried out by one inspector and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed other information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the 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 visited 15 people in their homes and spoke with 18 people on the telephone. We spoke with ten relatives, 12 members of staff, seven locality managers, the registered manager the performance coach, the regional managing director and one Dimensions associate family consultant. We reviewed ten care and support plans, five staff personnel files and other records relating to the monitoring and management of the service.

# Is the service safe?

## Our findings

The service remained safe.

People told us they felt safe at home and with the staff supporting them. Comments from people included, "Definitely, they just generally make me feel safe", "The staff are kind and I feel safe with them", "I do feel safe with the staff. I feel that I can talk to them about anything."

Comments from relatives included, "I've never had any issues with the staff, or my sons safety. I'm pretty sure that they keep him safe", "On the whole, our daughter is safe, very much so" and "I think that the staff are very thorough when it comes to safety. They carry out risk assessments with all the medical professionals."

Staff received safeguarding training with regular updates. The staff we spoke with were knowledgeable about their responsibilities to report any concerns. They were able to give examples of what constituted abuse or neglect and who they would report their concerns to. One staff member told us "It is everyone's responsibility, I have a duty to alert the safeguarding team of any disclosure or suspicion of neglect." Another said, "Any issues are to be reported straight away." The provider had a safeguarding policy in place and we observed guidance for staff (including the contact details of the safeguarding authorities) in the service locations.

Staff were also knowledgeable about their responsibility to whistle-blow and a policy was in place. Whistleblowing is the term used when a worker passes on information concerning wrongdoing. Whistleblowing procedures ensure that the whistle blower is protected from reprisals when they raise concerns of misconduct witnessed at work. One staff member told us, "I would report anything I saw that I knew wasn't right."

People were supported by staff who followed appropriate financial processes. Each person had their own individual safe in their room. Log sheets of money transactions, purchases and receipts were kept and checked weekly. Some people had appointed a representative or had a relative with a Power of Attorney to manage their finances on their behalf. One relative who was also an Attorney told us "[person's] money is safe, the staff keep a log, which I look at. I trust every member of the team with taking [person] out with her money."

People were protected from risks. Care plans contained risk assessments for keeping people safe whilst also maximising their independence when in their homes and when accessing the local community. Risk assessments were personalised and contained clear actions and outcomes to guide staff on how to keep the person safe. For example, one person was at risk of epileptic seizures and staff were given clear guidance on how to support them in the event of a seizure. This included specific instructions on how to manage these events when out and about in the community.

Each service location had an on-call system in case of emergencies. This meant that staff were able to gain

managerial advice and guidance if any concerns were raised at any time. Each person had a personal emergency evacuation plan in place. Each service had fire safety equipment and evacuation procedures clearly visible. Grab bags with essential information for each person were placed close to exits.

Staff were recruited safely. Pre-employment checks were completed. These included references, identity checks and DBS. A DBS check allows employers to make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable groups of people.

There was enough staff on duty to meet people's needs. The provider said staffing levels were based on people's needs and the activities they wanted to attend. They said there were always two waking staff on duty at night. All of the staff we spoke with confirmed they felt there was always enough staff available. The relatives we spoke with told us that staffing levels had improved. Comments made by staff included, "Staffing has improved enormously, not just the amount of staff but the type of people we have" and "There is no-one I wouldn't want to work with, I trust them."

Medicines were managed, administered and stored safely. The provider had a medicines policy and each service had appropriate PRN (as required) protocols for people's individual medicines, in place. Staff told us they had training in medicines administration. This included how to complete a medicines administration record (MAR) and recording when a medicine had been refused. Stock checks were completed daily and a full medicines audit was carried out weekly.

People were protected from the risks of infection. Staff told us they had training in infection control practices and we observed hand gels, paper towels and personal protective equipment (PPE) in place. People's homes were clean and tidy and there were cleaning rotas in place. Where people were able, they were also involved in helping to clean their homes alongside staff. People were supported to undertake safe hygiene practices in their kitchens for example, being reminded about hand washing.

The provider monitored accidents and incidents and reflected on them as a means of improving safety for people. The staff used the services incident reporting system and these were discussed during team meetings to promote shared learning. Managers analysed the documented incidents in order to assess for patterns, themes and making improvements. For example, when a medicine error was reported the response was to provide additional measures, a personal medicine cabinet was provided, double checking and re-training for staff.

# Is the service effective?

## Our findings

The service remained effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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 particular 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people receiving care in their own home this is an order from the Court of Protection. We checked whether the service was working within the principles of the MCA.

The staff we spoke with were knowledgeable about the MCA and described how they would put the principles of the Act in to practice. For example, offering the person choices in what to wear, what to eat, what to do. One staff member told us, "If they don't want to go to day services on that day, they don't have to go, it's their decision." If the person lacked capacity "I would make a decision in their best interest for them to wear a cardigan for example, because it was cold."

People's care plans contained 'consent to share' forms. These detailed aspects of the persons support which they had agreed could be shared with other people, for example the local authority or photographs on display. Where relevant, the service had made the local authority aware of a potential deprivation of liberty, these had been completed correctly. However, not all mental capacity assessments and subsequent best interest decisions were formally recorded, where people lacked the capacity to make a decision. This meant that there wasn't a record to show the service had considered the person's capacity to consent to receive care and the legal assessment process was not always followed correctly.

People's needs were assessed prior to accessing the supported living service. Individual needs were assessed and reviewed annually or when there were any changes. Support plans were person centred and included areas such as 'things important to me', life histories as well as comprehensive assessments of physical and emotional needs. Each person had a one page profile in their support plan. A one page profile is a simple summary of what is important to someone and how they want to be supported.

Staff were knowledgeable about the people they were supporting and were competent in their roles. The staff we spoke with told us they had training in line with the social care information and learning services care certificate, during their induction. This included (among other areas), health and safety, safeguarding, medication and equality and diversity. Staff also had access to the providers mandatory training and were trained in specific areas relevant to the people they were supporting such as epilepsy. Staff told us they were encouraged to develop by undertaking their intermediate and advanced diplomas in health and social care.

Staff had access to regular one to one meetings with their line manager. The staff we spoke with told us they had formal meetings five times a year and an annual appraisal. They were able to access one to one informal supervision at any time for example, if they had been supporting a person with complex needs. This meant staff could discuss any difficulties or challenges they faced with their line manager.

People told us they enjoyed the food they chose to eat and we observed people enjoying their meals. One person told us, "I like the food I have, I have what I want." There was evidence in care plans about people's likes and dislikes and how they preferred to prepare and eat their meals. Some people had specific guidance from speech and language therapy in their support plans, regarding safe swallowing techniques. We observed people being offered snacks and drinks regularly. One relative told us, "[my relative] is given two options of cooked tea to choose from. He chooses what he wants to buy."

The staff we spoke with told us they worked with professionals such as learning disabilities nurses and occupational therapists to deliver effective care to meet people's needs. People had full access to medical professionals when this was required. For example, one person was supported to attend many medical appointments prior to surgery. During surgery, staff stayed with the person in hospital to provide continuity of care.

# Is the service caring?

## Our findings

The service remained caring.

People told us the staff were caring. People received support from kind and friendly staff. Comments included, "I do think that the staff are caring. They know me well and help me with the things that I struggle to do on my own", "I think the staff care, nothing is too much trouble for them. They know me well and we get on fine", "Kind, supportive, caring definitely."

Relatives we spoke with were also complimentary about the standard of care and support their loved one received. Comments included, "I think that the staff do care. One staff member, [name], has been with [my relative] a long time and [they are] very, very good", "They have built good relationships and taken great care to get to know my [relative]. They have a tremendous amount of patience and they have taken time to get to know him and his likes and dislikes and things."

The staff spoke with great passion about how they wanted to provide a high quality service and empowering support to people. One staff member told us, "It's in the culture, we are going to enable [them] to do the things they want to do. We are constantly challenging." Another staff member said, "[The people] are definitely happy, well cared for, have autonomy and choice, they are happy."

Staff we spoke with knew the person they were supporting well. For example, two members of staff were able to describe what the person's expressions and gestures meant. An arm raised alongside a large smile meant the person was 'very happy'. Blowing raspberries meant the person was not feeling happy or didn't like something.

Staff members were also matched to the people they were supporting. The service held staged interviews when recruiting staff. Part of the interview was to find out about their interests or experiences so they could be matched to the person they would support. The person being supported was involved in the interview process.

We observed a conversation between a person and a staff member regarding the idea of visiting a friend and building the relationship. The staff member listened carefully to the person and assisted them by offering the idea of 'a step by step approach', giving an explanation of how to manage the development of the relationship in stages. There was lots of reiteration, 'its your choice, what would you like to do?' and 'what do you think?' A friendly, gentle and supportive chat with the onus always on the person being in charge but with an emphasis on safety.

Staff provided support which was dignified and respectful. Examples of how this was achieved included, "I always knock the door, say who it is and ask to go in", "I always ask permission before I do anything". Care and support plans were written respectfully and we observed many kind and compassionate interactions between staff members and people. All staff had a one page profile. A one page profile is a simple summary of what is important to a person and how best to support them. By completing their own profile, staff

understood which elements were important to consider when receiving personal and emotional support. They were more able to understand person centred support from the perspective of the person receiving it.

A locality manager had made changes to the rotas and staffing of other localities in order to return a much loved support worker to one person's support team more frequently. The staff member was also able to act as a driver which made the person very happy. The person told us, "Yeah I'm very happy." This meant the person was able to access the community more often and try new activities which was part of his goal.

## Is the service responsive?

### Our findings

The service remained responsive.

People told us that they had been involved in the development of their care and support plans. "I do have a care plan and when I started with Dimensions they went through all the paperwork with me" and "I am happy with how I am supported. I do have a care plan and I say the things that I want to be in it. I do feel involved and can change or add things if I need to." Relatives told us they were kept informed of any changes and were involved in reviews. One relative told us, "[my relative] has health plans and a care plan, all sorts of things. They do consult us if they want to make changes. We get a weekly written report and I know that if I phone they will always answer it."

The staff we spoke with were complimentary about the new electronic system for recording people's information and storing documentation relating to their support. One staff member told us, "It's a quick and easy system, the more we can get from paper files onto [the system] the better". "It allows us to take a photo of something that has happened rather than write it down." The system used a social media application to record events or experiences that the person would like to be kept in their daily support records. This meant that the person was able to look at the pictures about them, show them to others if they wished and be interactive in the information held about them.

The new electronic form of care planning was readily accepted by staff and gave clear outcomes for people's personal development. The system used eight support domains to provide person centred care, in goal stages. Outcomes were banded as red/amber/green. When one goal was achieved the outcomes would move through the stages of red to green. Trained staff from other locations (known as 'sponsors') go into different locations (not their own) to objectively monitor its use and efficiency.

The provider was fully compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given.

People and staff communicated using different methods. For example, some people were able to communicate using pictures and diagrams. Others were able to use an electronic device or smartphone. Some people with a sensory impairment had guidance for staff on how best to support the person to hear well and other people were able to use Makaton (a system of signs and symbols to aid communication).

Concerns and complaints were managed appropriately. One person told us that they were very able to say if they didn't like something or wanted to change anything. Other comments from people included, "I did have complaints explained, but I've never needed to make one." Another person told us that they had made a complaint and were satisfied with the outcome, "Once, that was dealt with very quickly."

Where appropriate, people's end of life wishes are recorded. Discussions around end of life care planning was offered to people. Some people or their representatives declined, but the service had developed a

comprehensive end of life plan with one person in conjunction with the local hospice service. The person had been at the centre of the development of this plan and had made requests and choices of things they would like to do and where they would like to be cared for. The person had decided they wanted to stay at home. The staff had found innovative ways to fulfil the person's wishes on their bucket list.

## Is the service well-led?

### Our findings

The service remained well-led.

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

There was a clear management structure in place, which had recently been revised to make the running of the service more effective. The management tiers of staff and rotas (including on call) had changed to allow managers to have specified rota'd time off. This had improved staff work life balance and the efficiency of the service being provided.

The staff we spoke with were very happy with the support they received from managers, comments included, "they are all on the ball I cant fault them" and "I can talk to [my manager] about anything, they are always there." The service holds recognition awards. One staff member told us, "If you feel valued you will value others, we are reminded that we are pivotal, we are appreciated and given credit."

The values and ethos of the service were evident throughout the staff group. The statement of purpose was available to all staff. Staff we spoke with told us they admired the emphasis on person centred care and enablement. One staff member told us, "I came to work for Dimensions after hearing the Chief Executive talk passionately about enabling people to live their own lives in their own homes." The director spoke passionately about a new well being programme being delivered to all staff. The philosophy around the programme helps people to build better relationships which improves performance. The regional managing director told us, "Staff need to feel valued. If staff don't feel valued how will that feel like for people?"

There were comprehensive systems in place to monitor the quality of the care being provided. The registered manager told us, "I am looking for continual improvement. We have a first families forum meeting in July, which we are encouraging all relatives to attend." The service regularly requested and received feedback from people and their relatives and had introduced 'good news stories' on social media celebrating what they did well.

The service was increasing and had recently taken over new services from other local providers. They were undertaking focus groups on 'relationships' which involved people, relatives and staff. Nationally, Dimensions had rolled out a community engagement programme. The registered manager told us, "We have spoken to managers and met with staff and it was identified that there was some community engagement lacking. There are pockets of it but we want to spread it out so that more people are engaged in local communities."