Independent Community Care Management Limited

ICCM Ltd - Telford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 30 May 2018 and was announced. At the time of our inspection 67 people were using the service.

ICCM Ltd - Telford is a domiciliary care service providing complex and clinical care to older adults, younger adults and children with profound disabilities, spinal cord injuries, acquired brain injuries and other neurological disorders. It is registered to provide personal and nursing care to people living in their own homes throughout England. It is also registered with us to provide treatment of disease, disorder and injury.

A registered manager was in post and was present during our inspection. 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.

Registered providers are required, by law, to notify the CQC when any details affecting their registration change. The provider had failed to notify us of a change to their company address which happened in March 2018. They took action during our inspection to ensure this was rectified.

People raised concerns about the consistency of the staff that supported them. Each person had their own team of staff who provided up to 24-hour care. Where people did not have a full staff team, they were supported by the provider's rapid response team or agency nurses. People did not always feel safe when the supported by these staff, because they did not know their care needs as well as their own staff team.

Despite the provider having safeguarding procedures in place, these had not been followed by managers in one instance. This placed people at risk and meant investigations had not been carried out as required.

Risk assessments reflected how care should be provided to the person to minimise any risks to them; they were regularly reviewed to adapt the level of support needed in response to people's often rapidly changing needs. However, where staff had raised concerns about one person the provider had failed to assess the risks associated with those concerns.

Systems were in place where managers monitored and reviewed the quality of the service provided to people. However, they had not identified that action had not been taken in response to the one safeguarding incident or staff concerns. The provider was already aware of the inconsistency of staffing for some people and was taking action to address this.

Some people felt communication from managers needed improvement, because they were not informed when there were changes to their care provision and staffing arrangements.

People received their medicines when they needed them. Staff were recruited safely to ensure they were

suitable to work with people within their own homes. People were protected against the risk of infection.

People's care and support needs were assessed and the provider followed good practice guidance to help ensure the care provided was effective and current. People were involved in the planning and review of their care and were encouraged to express their views, preferences and wishes regarding their care, support and treatment. This included any end of life wishes they had.

The training staff received was specific to people's individual needs. Staff practice was assessed and continually monitored to ensure they were competent to meet people's complex and specific needs.

People were supported to eat and drink enough and risks associated with these were assessed and monitored to ensure people's safety. Staff worked in partnership with other professionals and people confirmed they received the support and treatment they needed to maintain their health.

People were supported to have maximum choice and control of their lives and care workers supported them in the least restrictive way possible. Staff supported people to make decisions about their care and treatment. Where people could not make their own decisions, the provider worked within the law to ensure their human rights were respected.

Most people had developed positive relationships with their staff teams and agreed all staff were kind, caring and compassionate. Staff ensured people understood the information they received about their care. People were treated with dignity and respect and staff supported people's independence.

People received care and support that was individual to them and took into account their diversity. Staff understood people's routines and preferences and supported their social needs.

People understood how to make a complaint and there was a system in place to investigate these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from risks because the provider's procedures were not always followed by managers. People did not always receive their care from the same staff which impacted on how safe they felt.

People received their medicines when they needed them. The provider had systems in place to prevent the risk of infection. Staff understood their responsibilities to report incidents and accidents.

Is the service effective?

Good

The service was effective.

People's care and support needs were assessed using good practice guidance. Staff received the training they needed to ensure they had the skills, knowledge and experience to deliver effective care. People had the support they needed to eat and drink enough. The provider worked with other organisations to ensure there was a joined up and effective approach to people's care and support. Staff sought people's consent before providing assistance to them.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect and felt involved in their own care. Staff respected people's privacy and dignity when they supported them. People were supported to make choices in the way their care was provided.

Is the service responsive?

Good

The service was responsive.

People received the care they wanted and that was reviewed regularly. People were provided with opportunities to make comments or raise complaints about the care they received.

People were asked about their end of life wishes and care plans were developed to reflect these wishes.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not acted in accordance with their registration by notifying us of a change of address. People felt communication from managers could be improved.

The provider had recognised some areas of improvement and had implemented an action plan to ensure actions were taken to make improvements to the consistency of care people received.

People were encouraged to provide feedback on the quality of care they received. Staff felt supported in their roles and understood what was expected from them.

ICCM Ltd - Telford

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 was announced. We gave the provider five days' notice of our inspection because we needed to confirm which people we could contact to talk with them about their experiences of the service. We also needed to be certain a member of staff would be available at the service's office.

Inspection site visit activity started on 25 May 2018 and ended on 30 May 2018. It included telephone calls to people and their relatives. We visited the office location on 30 May 2018 to see the registered manager and staff; and to review care records and policies and procedures.

The inspection was carried out by one inspector, one inspection manager and one expert by experience, who conducted telephone interviews with people and their relatives. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR) in April 2018. 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.

Prior to our inspection we reviewed information held about the service. We looked at our own system to see if we had received any concerns or compliments about the home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We contacted commissioning teams and representatives from the local authority and Healthwatch for their views about the service. Where we received feedback, we used this information to help us plan our inspection of the service.

We spoke with 12 people who used the service and five relatives. We also spoke with six staff which included

the head of operations, clinical nurse manager, care staff, clinical nurse specialists, the operations director, the HR director and the registered manager. We looked at six care records, including medicine records and records of consent. We also viewed other records related to staff recruitment, complaints and records relating to how the service was managed.

Requires Improvement

Is the service safe?

Our findings

People were not always protected against the risk of abuse. We saw a complaint from a person where they had also made a disclosure that a staff member had been abusive towards them. Although the complaint had been discussed with the person and dealt with by a manager, the allegation of abuse had not been. The registered manager confirmed the allegation had not been discussed with the person. No referral had been made to the local safeguarding authority and we had not been notified of this allegation of abuse. We saw the provider had systems in place for ensuring people were protected against the risk of abuse or discrimination. However, in this instance these systems had failed and put this person at an increased risk of harm because the registered manager did not identify where people were potentially being abused.

People expressed concerns about a lack of consistency with the staff they had. They told us this had an impact on how safe they could feel with staff. One person said, "The carers however are all nice and they do their best and look after me well but the lack of continuity of care gets me disrupted. I am worried about not having another competent staff to cover me." Some people told us despite being supported by ICCM – Telford for many months, they did not have a full staff team to support them. One person said, "I was promised my own team but I get rapid response or agency. I have loads of agency staff and they still have not got me a full team. It is being filled in with rapids." Another person said, "Recruitment can take far too long and this concerns me." We spoke with the registered manager about what people had told us. They confirmed this issue had already been identified and the provider had introduced a new team of staff called the rapid response team. This team worked within set geographical areas across the country and were available at short notice, if needed, to cover where there were gaps in staff teams. We found that most people were happy with this arrangement until permanent staff could be found to support them. However, one relative told us they did not feel they could leave their family member when they were supported by the staff from the rapid response team. This was because they did not have confidence in them.

The registered manager told us they had seen a reduction in the use of agency staff because of this new team. However, agency nurses were still being used where there were shortfalls with nursing staff and people felt this inconsistency did have an impact on them. This was because they felt some of these agency nursing staff did not have the clinical competence that the ICCM – Telford nurses did. The operations director told us staff recruitment and retention had been identified as a priority and plans were in place to recruit new staff. This showed the provider was aware of people's concerns regarding an inconsistency in staffing and were taking action to improve this for people.

Apart from the concerns about the inconsistency of staff from the rapid response team and agency, people felt safe with the permanent staff teams they had. One person said, "I have epilepsy and am prone to seizures. I feel quite safe in their (staff's) company supporting me in case a seizure occurs." Another person said, "I feel very safe with the carers, they are all brilliant." The staff we spoke with confirmed they had received training in how to recognise and report actual and alleged abuse. They could tell us how the people they supported could be at risk of harm. Where staff supported children, they completed training specifically for safeguarding children. Staff were clear they needed to report their concerns to managers at ICCM – Telford. Our records show that, except for this one allegation of abuse, safeguarding referrals had

been made where concerns were identified and we have been notified. The CQC requires providers to notify them of any allegations of abuse or suspected abuse, as well as any serious injuries people sustain.

Risks to people had been assessed and were kept under review. However, where one person was known to have behaviour which challenged staff, these risks had not been assessed. We saw staff had raised concerns about the effect one person's behaviour had on the team. Despite this, the provider had not assessed the situation or any risk to the staff team. This meant staff did not have guidance from the provider and staff may not provide a consistent approach to mitigating risks associated with the management of the person's behaviour.

All other records we viewed contained risk management plans, which detailed how staff should support people to help reduce any identified risk. These covered risks to people's wellbeing and safety, such as the use of equipment as well as risks identified within people's own homes or other environmental factors. It also included risks associated with people's individual medical conditions. Risk assessments identified where people were at risk due to their medical conditions or medical equipment they had in place, such as ventilators or tracheostomies. One person told us, "I have a standalone hoist and feel quite safe with them all (staff) when transferring me about. They support me well, ensuring I cannot fall."

Before prospective staff started work at ICCM - Telford, they were subject to reference checks and checks with the Disclosure and Barring Service ("DBS"). DBS checks are used to vet staff and prevent unsuitable people from working in care. Registration details for nursing staff were checked with the Nursing and Midwifery Council to ensure these were valid and current.

The provider had systems in place to ensure incidents and accidents were analysed and lessons learnt from these. Records of accidents and incidents were maintained and viewed to help identify traits and the actions needed to reduce the risk of reoccurrence. The provider and the registered manager had processes in place to investigate and address any concerns about staff conduct and we saw disciplinary action was taken, where needed.

People were supported by staff to take their medicines when they needed them. One person told us, "I cannot take medicines myself, they (staff) give them to me and make sure I swallow them safely." Another person said, "I have a blister pack for my medicines. I can take them myself and they (staff) make sure I have them on time. No problems with my medicines." We saw any risks associated with people's medicines had been assessed and plans were in place which gave staff clear direction on how to support people with their medicines. Where people required medicine to be administered only when they needed it, such as pain relief, clear protocols were in place. These protocols directed staff to recognise and understand when people might need these medicines. Staff told us they had received training in the safe management of medicines and administration of people's medicines and were regularly assessed to ensure they remained competent to support people as needed.

People were protected by the prevention and control of infection. People were happy their care was provided in a clean and safe way by staff. Staff confirmed they had received training in infection control practices. Hand washing guidance for staff was in place and the clinical nurse managers ensured care staff followed these. People had infection control guidelines and infection prevention tools in use where risk was indicated, for example, due to them having a long-term catheter in place.

Good

Is the service effective?

Our findings

People and their relatives felt confident the staff had the skills and knowledge they needed to provide their care. One person said, "Staff are all well trained. I have full confidence in all of them." Another person said, "The carers are all good, all trained and clued up. Very friendly and nice and very helpful to me."

Staff received the training they needed to help ensure they provided effective care. All staff attended structured induction training, which also included training specifically for the person they supported. Staff worked in teams to solely support one person who may require up to 24-hour care and support. Training therefore had to be person specific as each person had different and complex care needs. Staff were trained and assessed to a specific set of competencies such as supporting people with tracheostomy care, ventilation or gastrostomy. Staff told us they had also received training related to specific medicines people took and training around spinal cord or acquired brain injuries. One nurse told us they had completed moving and handling training specifically for children with complex needs and were now able to help train other staff.

Clinical nurse specialists confirmed the service had good links with local hospitals. We spoke with one clinical nurse specialist who oversaw care to children. They told us they kept up to date with clinical practice by using resources from and liaising with national and local children's hospitals and following NICE guidelines. NICE is the National Institute for Clinical Excellence. They provide national guidance and advice to improve health and social care.

People's needs were assessed prior to being supported by staff. The registered manager told us people would be visited in hospital so their needs could be assessed to ensure the service could support them effectively. They said, "We need to make sure we manage people's expectations about what we can do." The PIR stated these assessments were nurse led and helped them to understand what the person wanted and needed, not only in relation to their care and clinical needs but also their social and emotional needs. People would only be discharged from hospital once all equipment and resources were in place at the person's home. This involved staff working with other healthcare professionals to ensure equipment such as ventilators or mobility equipment were in place. It also enabled staff to be trained on the specific equipment people would use.

Staff worked in partnership with other professionals on an on-going basis, to ensure people's health needs were met. We saw advice and information provided by professionals was included in people's care plans and risk assessments. The registered manager told us there was a strong focus on health and social care professionals working together to meet people's needs. Staff attended multidisciplinary meetings with local hospitals and Clinical Commissioning Groups (CCG's) to discuss the individual needs of people and share information on the care being provided for them. Feedback from CCGs we received, was positive. This helped to ensure people received effective care.

People were supported to eat and drink enough. People we spoke with had varying amounts of support with their nutrition. One person said, "They cook my meals for me. I require help with eating which they do for

me, ensuring I am able to swallow safely." We saw where people were at risk of not eating enough or had difficulty with eating and drinking assessments had been completed to ensure people were supported safely and effectively. Some people had additional dietary needs and due to health conditions were unable to swallow food or fluids. These people required all their nutrition via a percutaneous endoscopic gastroscopy (PEG). A PEG is a feeding tube that is inserted directly into a person's stomach. Staff had received training to administer nutrients via a PEG. One person's relative told us staff knew how to use the equipment correctly which helped to ensure they received the nutrition they needed to stay healthy and safe.

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. Staff we spoke with understood their roles and responsibilities regarding gaining consent and what this meant or how it affected the way the person was to be cared for.

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. Providers must make applications to the Court of Protection for people living in their own home. Staff understood the importance of ensuring all decisions made on a person's behalf had to be in that person's best interest. Where staff supported children, they involved parents in gaining consent to support the child with day to day care. The provider had systems in place to ensure staff worked in accordance with the MCA. We saw MCA capacity assessments and best interest decisions were used where decisions needed to be made on behalf of people. Where one person was protected under the Court of Protection we saw decisions were made by a multi-disciplinary team. This was because the person lacked the capacity to make their own informed decisions in a certain aspect of their life. Despite this person having limited capacity we saw they were involved in all decision-making meetings and their opinion was always sought. This helped to ensure that people's rights were protected and their best interests considered when decisions were made on their behalf.

Good

Is the service caring?

Our findings

People and their relatives told us their care staff had taken the time to get to know them well, and treated them with kindness and respect. They described care staff as "nice", "friendly", "patient" and "caring. They told us staff spoke to them with respect, and listened to what they had to say. One person told us, "All carers are helpful and supportive to my needs and nice and friendly toward me." Even though people received care from staff in the rapid response team, they agreed they were kind, caring and compassionate. One person said, "The carers themselves are all nice and helpful, no issues with them personally."

Because some people required 24-hour care, staff were in people's homes for long periods of time. One staff member told us because of this it was especially important to develop positive relationships, not just with the person they supported, but also with their families. They said about the person they supported, "It is an honour to go in their house, the family allowed us to come into their family home and support [person's name]. We have to respect their family life. I consider myself to be their friend on the side-line."

Staff ensured people were involved in their care and supported to express their views. People told us they felt fully involved in what happened to them with regards to their care and support. The clinical nurse specialists told us they took time to sit and talk with people and their families to ensure they always understood information and options about their care. One said, "We take the time to sit with them (people) during clinical visits so they have the time they need to express themselves and ensure their wishes are communicated to us and respected."

Staff we spoke with demonstrated they understood people's individual personalities, needs and preferences. They confirmed they received training in equality and diversity and how to support people with diverse needs. This supported staff to treat people as equals and ensure their care was appropriate to them as individuals. One staff member said, "We don't treat them (people) any differently just because they have disabilities or complex needs. I treat everyone as an equal, I respect them and I respect their religion and beliefs."

People and their relatives told us staff treated others in a respectful and dignified manner, and that they actively sought to promote people's independence. One person explained to us that staff only supported them with what they had to. Where they were able to take over from staff they were encouraged to do so, such as staff preparing their food so they were able to eat independently.

People told us that staff respected their privacy and dignity. One person said, "They (staff) do all my personal care and privacy and dignity is fine. They keep me covered up and door closed." We saw dignity and respect was a priority in peoples care plans as some clinical interventions were very personal. Staff we spoke with told us they were always mindful of this when they supported people.

The registered manager and staff members understood the importance of keeping people's personal information confidential. People's care plans were kept in their own homes. Copies of people's care plans were kept in a locked cabinet in the office, to make sure they were only accessible to people who had the

authority to see them.

Good

Is the service responsive?

Our findings

People and their relatives were satisfied with the service ICCM - Telford provided. They told us it met their individual needs and requirements and they received care that was personal to them. However, where some people received care from the rapid response team they felt these staff did not know them or their needs as well as they would have liked.

Staff understood people's routines and their care plans reflected this, along with their wishes for how they wanted their care delivered. We saw one person's care plan identified they liked to be woken up with a drink. Staff also showed a good understanding of the personalities, preferences and wishes of the people they supported. One staff member said about the person they supported, "We've got to know [person's name] so we can tell just by looking what mood they are in or if they are not happy. They enjoy us reading stories, talking to them and using sensory activities. We get no response, but on the odd occasion we may get a smile or laugh. That is lovely to see." This staff member spoke at length about the preferences of the person they supported, but we found this depth of information was not reflected in the person's care plan. We spoke with the registered manager about this and they assured us they would get this reviewed.

People's care plans were individual to them, and covered their current nursing, care and support needs. People told us these were kept updated. One person said, "We all, family and I have input into my care plan. We do this with [clinical nurse specialist's name] who is very much approachable." Care plans detailed clinical interventions people needed along with their physical, emotional and social needs. People and their families worked in partnership with staff to plan the support needed in these areas. One relative told us staff supported their family member to follow their interests and were currently putting a book together, with their family member, to display what they liked and when, which would be useful for any new staff.

We saw where people had communication difficulties which could prevent them from expressing their wishes, communication care plans were in place. These care plans directed staff on how to support people with effective communication. One person had communication aids on their computer and staff were prompted to use pictures or rephrase and simplify questions if they were not understood. All providers of NHS and publicly-funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. We found consideration was given when people required information in alternative formats.

People and relatives felt they had a good relationship with their own staff team, which meant they could share their views and concerns with them at any time. People and their relatives were clear about how to raise any complaints about the service with managers and the provider. However, we received mixed responses on how well concerns were dealt with when these had been raised with managers. One person said, "I have made an official complaint and the new care manager is trying to address the situation. Things have improved since and I now get a monthly rota which I didn't before." Whereas another person told us their concerns were not responded to and they did not feel reassured improvement would be made. The provider had a complaints procedure which helped to ensure all complaints were handled in a consistent

and fair manner, a copy of which was provided to people who used the service. We saw where complaints were related to policy or procedure, information was fed back to staff to act as reminders about their practice.

People were supported to talk about their views for their end of life care, where appropriate. The registered manager told us if people did not want to discuss end of life wishes this was respected. We saw people had advanced care plans in place which contained information about their wishes during their final days and following death. One clinical nurse specialist told us staff worked alongside local community nursing teams to make sure any equipment or pain relief was available and people were comfortable.

Requires Improvement

Is the service well-led?

Our findings

Registered providers are required, by law, to notify the CQC when any details affecting their registration change. During our inspection we identified the provider had failed to notify us of their change of address. The registered manager and operations director both confirmed the registered address of the provider had changed in March 2018. Whilst this did not directly affect the regulated activities being provided by the location (ICCM – Telford), this meant the registered provider had not fully complied with their registration responsibilities. The provider took action during our inspection and submitted the correct notification to ensure they were correctly registered with us. We therefore, were assured we had been informed of the correct registered details for the provider and will not take any further action.

People and relatives gave us mixed opinions about the effectiveness of managers and some felt there was a lack of communication from managers. One person told us, "Communication could be better". Other people told us they did not receive rotas, which would tell them which staff were coming to support them. They also did not get told when there were changes to the rotas. The registered manger told us they had recently identified this as an issue and thought this was because staff were emailing changes to people, not contacting them by telephone or in person. They said, "Email is not personal but phone calls are. We need to be open and honest when there are changes. We have to build relationships with people." Other people and relatives we spoke with told us they felt communication was good between them and managers and they had no complaints. One person said, "Contact is good with them all. I am very pleased with the service."

People were involved in interviewing their own staff. However, some people told us despite this they still did not have a full staff team. They felt frustrated when they were not told by managers the staff they helped to recruit had left the company. One relative said, "The company, as a whole, has its heart in the right place. But they certainly need to sort out the recruitment issues and improve on the communication from managers to us."

The provider had quality assurance systems in place which helped to monitor the effectiveness of the service. Regular checks were completed on key areas of the service and the care people received, such as medicines, care plans and infection control. Staff practice was monitored and clinical competencies were assessed and kept under review. Nursing staff kept up to date with best and current clinical practice and this was shared throughout the service. The registered manager had overview of the service and attended clinical meetings with other managers to ensure evidence was gathered from incident reports and that action had been taken and lessons were learnt where needed. The registered manager told us they worked with the provider, operations director and head of governance to implement the changes needed to help ensure the quality of the service. Although there was a known issue with people not always receiving a consistent service, we saw the provider had already implemented actions to improve on this. We will check this at our next inspection to ensure people are receiving a consistent service.

People's views on the service were sought by the provider through yearly surveys. These included formal surveys and also through visits by the clinical nurse specialist and care managers to people and their relatives. As a direct result of the last survey, the importance of dignity and privacy had been discussed with

staff during their supervisions with their line managers. This was due to a poor score in the survey, with five out of 15 people saying staff were not always kind and compassionate and did not always maintain their dignity. The operations director told us they planned to introduce more regular quality surveys with people being asked for their feedback either in person by telephone. At this inspection people told us staff were kind and caring towards them.

Staff we spoke with had a shared vision of wanting to provide the best possible care they could for people. They told us they felt supported in their roles by colleagues and their line managers and were clear on what was expected of them in promoting good standards of care.