Care Quality Commission

Westcountry Case Management Limited

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Inspection report

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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

Westcountry Case Management provides a specialist service and co-ordinates packages of care, support and therapy for adults and children who have a brain injury and/or physical injuries. Its services are commissioned by Deputies who have been appointed by the Court of Protection, solicitors, the NHS and clients by direct referral. The provider carries out assessments, and delivers care, support, and therapy focused on enabling people to recover from their injuries. Staff are recruited by the service but most staff are employed directly by the person themselves or the Deputy who manages their financial affairs. The provider oversees the training and performance management of case managers, team leaders and support workers. Throughout this report case managers, team leaders, and support workers are referred to as 'staff'.

The provider coordinates the service from their office base in Bishopsteignton. However, services are delivered across a wide geographical area in the south west of England and Wales.

The service had a registered manager. 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. Following our inspection, the care manager was interviewed by CQC and confirmed as the new registered manager. The registered manager was supported by a network of case managers located throughout the service's area of operations. Each case manager was a registered healthcare professional with a small caseload of clients specific to their area of expertise.

We visited the office on 13 December 2016. We carried out telephone calls to people and their relatives on 15 December 2016. At the time of this announced inspection 37 people were receiving personal care from the service. The service met all of our regulations at the previous inspection in January 2014.

People were happy with the staff who supported them. Comments included "My support worker is brilliant, keeps me on track, listens" and "We get on well, always laughing and joking." People had stable staff teams who had supported them for a long time and knew them well. Staff enjoyed their role and spoke about people with compassion. People received support from staff who respected their right to make their own decisions. People's independence was promoted and encouraged. People received support from therapists to regain skills they had lost. Care plans contained information about people's goals. Where possible staff worked to maintain people's previous lifestyle.

People and their relatives told us they felt safe when staff were in their home and when they received care and support. Staff knew how to recognise signs of potential abuse when supporting adults and children and understood how to report any concerns in line with the service's and the relevant local authority's safeguarding policy. Safe staff recruitment procedures were in place. This helped reduce the risk of the provider employing a person who may be unsuitable to work in care.

People benefited from effective care because staff were trained and supported to meet their needs. Staff told us they were happy with their training. Comments included "My training is up to date" and "Training is always on the agenda." Staff told us they felt well supported and had regular opportunities to discuss their work.

Care plans were detailed and person centred. They included information on what was important to each person, their interests, their goals, and their history. There was detailed information about the support the person needed to manage their day to day care and health needs. People told us they made decisions in relation to their daily activities. One person said, "We're always out and about." Care plans contained information about people's interests and the activities they enjoyed. A list of accessible venues for these activities was included such as the theatre, cinema, swimming pool, hydrotherapy, horse riding, cafes and pubs. People were supported to regain skills in daily living tasks. For example, one person had identified they would like to try cleaning and laundry to become more independent. Care plans were reviewed annually or when people's needs changed. There was evidence that staff monitored people's health care needs and responded to changing needs.

Risk assessments were comprehensive and took into account the person's needs and views of other people involved in the care provision. This included specialist advice sought from occupational therapists, speech and language therapists, physiotherapists and psychologists, as well as input from family members. Staff had clear information on how to manage and minimise risks to people. For example, we looked at detailed risk assessments relating to mobility, falls, bathing, skin care, and epilepsy. People were supported to take positive risks to develop their skills and independence.

Staff provided support and assistance with medicines where needed. Care plans contained clear information on how to support each person with their medicines and people told us they were happy with the way staff supported them. Staff told us they had completed training in safe medicines management and felt confident when assisting people. Team leaders and the case manager monitored the medication administration record sheets to ensure they were completed correctly.

People and their relatives felt able to raise concerns or make a complaint. They were confident their concerns would be taken seriously. People told us they didn't have any complaints. Where complaints had been received they had been managed in line with the company policy.

People told us they were happy with the service they received. Comments included, "They're well organised" and "It's going well." Healthcare professionals told us they had found the management to be professional and approachable. One professional commented, "Management and communication with Westcountry Case Management has always been efficient." Staff told us it was difficult for them to get into the office due to the large geographical area covered. However, they told us they felt the management team was approachable and supportive. One staff member said, "If you need anything you get a response." Another staff member said, "We work remotely and don't always get into the office but contact is very good."

Staff told us they had seen positive changes since the new registered manager had started work at the service. One staff member commented "Very good, there's been additional training." An audit system was in place to monitor the quality of the service people received. Records were checked by case managers on a monthly basis. The registered manager told us they had started to carry out clinical file audits to monitor quality and ensure information was up-to-date. There were also plans to carry out more regular checks, for example, to observe staff's competency and obtain feedback from people who used the service.

The provider and registered manager were keen to develop and improve the service. They kept up-to-date

with best practice and attended networking events and conferences to share good practice. The service also offered training to external agencies on case management and care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from risks to their health and wellbeing because assessments were carried out by appropriate professionals. People benefited from staff who managed positive risks to enable them to reach their potential.

People were protected from the risk of abuse through the provision of policies, procedures and staff training.

Safe and robust staff recruitment procedures helped to ensure that people received their support from suitable staff.

Is the service effective?

Good

The service was effective.

People benefited from having staff who were skilled and supported in their job role.

People were supported by a service who understood the requirements of the Mental Capacity Act including the involvement of families, professionals, and court appointed deputies.

People benefited from access to a range of health care professionals who were able to support them to regain skills.

Is the service caring?

Good

The service was caring.

People who used the service valued the relationships they had with staff.

People were involved in their care and able to make choices about how they wanted things to be done.

People benefited from staff who were aware of their individual communication skills.

Is the service responsive?

The service was responsive.

People received personalised care because care plans described what staff needed to do to support people well.

People were supported to access a range of activities and to reach their individual goals.

People were encouraged to give their views and raise concerns and complaints if the need arose.

Is the service well-led?

The service was well-led.

People benefited from an open culture and approachable management team.

The quality assurance systems were effective. Remote management arrangements meant the registered manager shared responsibility for quality assurance with locally based care managers.

The registered manager kept up-to-date with good practice and was developing a more robust audit system to monitor the quality of the service and make further improvements.

Care Quality Commission

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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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 13 and 15 December 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to make sure staff were available to speak with us. We made telephone calls to people and their relatives.

One social care inspector carried out this inspection. On the first day of our inspection, 37 people were using the service. We used a range of different methods to help us understand people's experience. We spoke with six people and two relatives on the phone. We spoke with the provider (who was registered manager at the time of our inspection visit), care manager (now registered manager), training manager, and five staff. We received feedback from twelve healthcare professionals. We looked at five care plans, three staff files, audits, policies and records relating to the management of the service.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe when staff were in their home and when they received care and support. Staff had completed training in safeguarding adults and children. Staff had a good understanding of safeguarding and knew how to recognise signs of potential abuse. They knew how to report any concerns in line with the service's safeguarding policy. Staff told us they felt confident the provider would respond and take appropriate action if they raised concerns. Staff also knew how to raise concerns outside of the service. As people lived in different geographical areas, staff had access to the relevant local safeguarding information.

Initial assessments were carried out to identify potential risks. This included risks relating to people's activities of daily living, their physical condition, and cognitive ability. Strategies to manage each area were put into place in the care plan where a full risk assessment was not required. We looked at one person's care plan which gave clear instructions on answering their door. The person liked to open their door if they knew the visitor. If they did not know the visitor, staff would answer the door.

Risk assessments were comprehensive and took into account the person's needs and views of other people involved in the care provision. This included specialist advice sought from occupational therapists, speech and language therapists, physiotherapists and psychologists, as well as input from family members.

Staff had clear information on how to manage and minimise risks to people. For example, we saw detailed risk assessments relating to mobility, falls, bathing, skin care, and epilepsy. Where one person was at risk of seizures, staff had clear instructions on how to prevent a seizure and what to do if the person did have a seizure.

People were supported to take positive risks to develop their skills and independence. For example, one person liked to do activities independently. The person was able to contact staff via mobile phone and they agreed a time to meet at the end of the activity. Staff encouraged the person to text them once during the activity to make sure they were safe.

Staff provided support and assistance with medicines where needed. Care plans contained clear information on how to support each person with their medicines and people told us they were happy with the way staff supported them. Staff told us they had completed training in safe medicines management and felt confident when assisting people. Staff signed a medication administration record sheet to confirm they had administered people's medicines as prescribed. Team leaders and case manager monitored the MAR sheets to ensure they were completed correctly.

Risk assessments relating to each person's home environment had been completed. Staff identified when people were not safe and raised concerns. For example, one person's bathroom floor covering had holes in it. This could present risks of trips and infection control. This was reported and repairs were arranged. There were plans in place to deal with foreseeable emergencies. For example, each person had an emergency evacuation plan. This included information on fire prevention, gas leaks, and exits from the premises. There

was information so that staff knew what to do and telephone numbers for emergency contacts.

There were enough staff to meet people's needs. Staff teams were recruited for each person. This meant people had small regular staff teams who delivered their care and support. Most people employed their staff directly. The provider worked with a small number of care agencies and people's financial deputies to interview, supervise and train staff. The provider directly employed two support workers. Where possible, people took part in the selection process.

Recruitment practices were safe. The staff files included evidence that pre-employment checks had been made including written references, satisfactory police checks (Disclosure and Barring Service or DBS), health screening and evidence of their identity had also been obtained. This helped reduce the risk of employing staff who may be unsuitable to work in care.

Incidents and accidents were monitored. Staff completed an online form which meant the incident was reported without delay and action could be taken when needed to minimise the risk of reoccurrence. For example, one person had trapped their fingers in a car door. Although this did not result in injury, staff encouraged the person to close the door in a different way to minimise the risk of it happening again. Information on the forms was used to create reports which identified patterns and trends. People took out Employer's liability insurance to cover them in the event of an injury to staff whilst working.

The service had policies and guidelines in place to prevent the spread of infection, and staff had completed training in infection control, health and safety, and food hygiene. Infection control risk assessments had been carried out in relation to hand washing, personal protective equipment, training, clinical waste, personal care, food and drink preparation, coughs and sneezes, laundry, and equipment.

Procedures were in place to ensure people's monies were protected. Where people were unable to make decisions in relation to their monies and kept small amounts of cash, the staff member coming on duty counted and checked the monies with the staff member going off duty. Monies were stored securely and there were clear guidelines in place. Transactions were accounted for and receipts were kept. The deputies appointed by the court of protection managed people's financial affairs. One healthcare professional told us, "Funds are spent with appropriate caution and budgets are explained to the team but I have never had any requests for equipment turned down".

Good

Is the service effective?

Our findings

People benefited from effective care because staff were trained and supported to meet their needs. Staff told us they were happy with their training. Comments included, "My training is up to date" and "Training is always on the agenda." Staff also received specific training on people's individual needs from healthcare professionals involved in their individual care. Healthcare professionals told us, "The staff have all attended training that I've provided. The staff I've worked with most closely have been welcoming of new ideas and suggestions. They always ask appropriate questions and demonstrate initiative with activities" and "The Case Manager is supportive to allow me to do training sessions with the team when introducing anything new/complex or when there is a significant change of staff."

The service employed a training manager who ensured staff had the knowledge and skills they needed. Each person had a training matrix which showed the training staff needed to complete to be able to meet their specific needs. Each staff member completed a self-assessment of their skills and knowledge. The provider then asked staff to give them evidence of any previous relevant training. Where gaps in training were identified, staff were then booked onto courses.

Staff who were new to care and who supported adults completed the Care Certificate. This certificate is an identified set of standards that care workers use in their daily work to enable them to provide compassionate, safe and high quality care and support. Staff who were new to care and supported children completed the Children's Workforce Induction Programme. This induction programme is an identified set of standards for staff to use to enable them to provide high quality care to children and young people. New staff completed shadowing, where they worked alongside the case manager and experienced staff to observe how people had their care and support delivered.

Experienced staff told us they were happy with the training they received. Staff told us they had completed training which was up-to-date in areas such as moving and handling, first aid, infection control, food hygiene, and health and safety. Training that was specific to people's need such as acquired brain injury and epilepsy had also been completed. Certificates were kept in staff's individual files. Staff were encouraged to develop their skills and knowledge by completing diplomas in health and social care.

Staff told us they had regular supervisions with the case manager for their team to discuss their work. During supervisions staff had the opportunity to sit down in a one to one session with their line manager to talk about their job role and discuss any issues they may have. Staff told us they felt well supported. Records confirmed that supervisions had taken place.

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.

Care plans gave detailed information on people's capacity to provide consent. People confirmed they were able to make decisions about their care and support. Where people lacked capacity to manage their finances, the court of protection had appointed a deputy to act on their behalf. Managers and staff had a good understanding of the Mental Capacity Act. The staff handbook contained detailed information on the Act and best interest decisions. The provider had assessed each person to ensure care was provided in the least restrictive way possible. Where they had identified that two people may be deprived of their liberty, they had contacted the relevant local authority to see if an application to the court of protection was needed.

Staff supported people to get they support they needed from healthcare professionals. People and their families were involved in decisions about which therapists would benefit them. The service had access to a range of healthcare professionals to support people with their specific care needs. One professional commented "Westcountry Case Management were very professional, supportive, responsive, and facilitated excellent interdisciplinary, interagency team working."

People received the support they needed with eating and drinking. Care plans contained detail information about the assistance people required. Where people had swallowing difficulties, speech and language therapists had been involved. They assessed their needs and provided guidance for staff. Healthcare professionals commented, "I am most impressed with how the team follow the recommendations made by the speech & language therapist and engage with (name) through every process. They also come up with very good ideas themselves to apply the recommendations" and "Despite (name's) complex physical needs all nutritional needs are met safely and any concerns reported in a timely way to allow my support."

Staff told us they encouraged people to plan healthy meals and choose healthy snacks. We saw evidence people were supported to lose weight, where this was appropriate. Some people had been assessed by a dietician to devise a weight management programme. Staff supported people to make a shopping list. People were encouraged to help with food preparation where they were able to. Staff knew to contact the office if they had any concerns in relation to eating and drinking.

Good

Is the service caring?

Our findings

The provider information return said, "The core values of treating clients with dignity and respect and listening to them is at the heart of all we do." People were happy with the staff who supported them. Comments included, "My support worker is brilliant, keeps me on track, listens" and "We get on well, always laughing and joking." Healthcare professionals told us that staff were caring. They said "(Name) currently has a lovely team of empathetic support workers"; (Name) is clearly well cared for and happy; and "When I visit the place is calm, relaxed and ultimately a happy environment." People had stable staff teams who had supported them for a long time and knew them well. Staff enjoyed their role and spoke about people with compassion. One member of staff described the person they supported as 'unique'.

People received support from staff who respected their right to make their own decisions and promoted their independence. People told us they were involved in decisions about their care and support. One person told us "I make the decisions." Where people had difficulty in making decisions, staff had clear guidance to enable them to make choices. For example, one person was offered a choice of two or three items of clothing so they could make a decision on what to wear that day. Some people liked to involve their family in any major decisions. Where care and support was delivered to children, their parents were involved in decision making. People who used the service and their families were involved in the selection of staff. As part of this they could assess whether they thought they could develop a good rapport. The staff we spoke with were able to describe people's needs and how they wanted to be supported. When we telephoned one person, staff spent time to explain our role to them. They checked the person was happy to speak with us and introduced them.

People's independence was promoted and encouraged. People received support from therapists to regain skills they had lost. Care plans contained information about people's goals. Where possible staff worked to maintain people's previous lifestyle and this could involve positive risk taking. For example, people took part in a wide range of activities.

Staff found ways to communicate with people in a way they understood. Care plans contained detailed information on how people communicated their wishes. For example, staff were given instructions to be patient, encourage the person to slow down when talking, and reduce distraction. They had communication guidelines from the speech and language therapist. Another person's speech could be difficult to understand and they used text messages.

Staff understood people's right to a private life and respected their privacy and confidentiality. Staff told us they recognised when people needed to be on their own and would go to another room so they were on hand to provide support if needed. They ensured they gave people time to talk privately with friends and family.

Care plans contained information relating to privacy and dignity. For example, "only enter with permission after knocking and waiting"; ensure bathroom blinds are close and remain in earshot, (name) will call when finished" and "When supporting (name) to clean teeth, stand to side of wheelchair and not face on as this

can appear intrusive."

Staff were aware that people could sometimes feel anxious or distressed. Care plans gave staff information on how to support people at these times. One person told us "If I'm down I talk to the staff. They chat, they listen, they're brilliant".

Good

Is the service responsive?

Our findings

People had a range of needs and the service provided a person centred approach to respond to those needs. Self-employed case managers worked with the service. The case managers were registered healthcare professionals such as nurses, occupational therapists, physiotherapists, speech and language therapists and social workers. The case manager's skills were matched to people needs. The case manager carried out an initial assessment, identified people's care needs and made recommendations to the solicitor to apply for funding. The case manager was responsible for overseeing the package and was supported by the clinical services manager.

Care plans were detailed and person centred. They included information on what was important to each person, their interests, their goals, and their history. There was detailed information about the support the person needed to manage their day to day care and health needs. Care plans were reviewed annually or when people's needs changed.

There was evidence that staff monitored people's health care needs and responded to changing needs. Regular team meetings were held and the frequency of these depended on the complexity of the person's needs. These were used to discuss what had happened for the person, the person's successes, such as booking a holiday, completing tasks independently, and exercises.

Multi-disciplinary team (MDT) meetings were held with a variety of healthcare specialists to ensure that people were supported to maintain good health and on-going support. Professionals told us, "There are regular MDT meetings, dates are planned well in advance and there is almost 100% full MDT attendance. These are really valuable and provide an opportunity for the team to meet and cross check that we are all heading in the same direction, what else needs to be done and by whom" and "Whenever I request information or feedback from MDT and more often the care team I always get a constructive response. This has enabled me to work efficiently to achieve my specific goals for (name)."

People told us they made decisions in relation to their daily activities. One person said, "We're always out and about." Care plans contained people's interests and activities they enjoyed. A list of accessible venues for these activities was included such as the theatre, cinema, swimming pool, hydrotherapy, horse riding, cafes and pubs. People were supported to regain skills in daily living tasks. For example, one person had identified they would like to try cleaning and laundry to become more independent. We saw people had daily exercise programmes to improve their mobility and movement. These had been designed and reviewed by physiotherapists and were supported by staff. One person told us staff supported them to go the gym every day. They said they weren't that keen on going but staff encouraged them and they were benefiting as a result.

Where people had difficulties with their memory, staff had responded by using methods to support them. For example, plans were written on a calendar and whiteboard; photos were available to remind the person of events and achievements; a diary of events was kept to record what the person had done and enjoyed. Staff provided feedback to the person at the end of their shift.

People and their relatives felt able to raise concerns or make a complaint. They were confident their concerns would be taken seriously. People had a copy of the service's complaints policy in their care plan file. This provided information on how to make a complaint. People told us they didn't have any complaints. The provider recorded any complaints they received. Where complaints had been received they had been managed in line with the company's policy.

Good

Is the service well-led?

Our findings

People told us they were happy with the service they received. Comments included, "They're well organised" and "It's going well." Healthcare professionals told us they had found the management to be professional and approachable. One professional commented, "Management and communication with Westcountry Case Management has always been efficient."

At the time of our inspection visit, the provider was also the registered manager. Following our inspection, the care manager was interviewed by CQC and confirmed as the new registered manager. The team included the director, senior management team, office manager, case managers, human resources, and administration and support workers. The registered manager was supported by a network of case managers located throughout the service's area of operations. Each case manager was a registered healthcare professional such as occupational therapists, nurses and speech and language therapists. Each case manager had a small caseload of clients specific to their area of expertise.

Staff told us they had seen positive changes since the new registered manager had started work at the service. One staff member commented "Very good, there's been additional training." Staff told us it was difficult for them to get into the office due to the large geographical area covered. They told us they felt the management was approachable and supportive. One staff member said "If you need anything you get a response." Another staff member said "we work remotely and don't always get into the office but contact is very good." Staff knew their roles and responsibilities. Comments from staff included "we've got a really good team" and "we get on well."

The service was a member of the United Kingdom Brain Injury Forum. All of the case managers had been qualified for at least seven years and were members of The British Association of Brain Injury Case Managers. The provider attended networking events and spoke at The World Brain Injury Conference in Holland in 2016. They planned to speak at other local and national conferences. Case managers attended a full three day conference each year. The service also offered training to external agencies on case management and care.

Records were clear, well organised and up to date. Most of the records were stored electronically on computer. The system was backed up daily to ensure records were maintained in the event of a system failure. Paper records were disposed of by shredding when no longer required.

An audit system was in place to monitor the quality of the service people received. Records were checked by case managers on a monthly basis. The registered manager told us they had started to carry out clinical file audits to monitor quality and ensure information was up-to-date. We saw this was a detailed audit for each person which involved talking with staff and looking at records. Where training needs had been identified as a result, we saw the training had been completed. There were also plans to carry out more regular checks, for example, to observe staff's competency and obtain feedback from people who used the service.

The provider asked people, family, staff, and professionals for their feedback on the service. Questionnaires

were sent out in November 2016 and they were awaiting the responses. The previous survey was carried out in 2015. There were 81 responses in total. The responses were mostly positive. We saw that where issues were raised, an action plan was put in place and action was completed. The provider was concerned that the response from people and their relatives had been low with only 20 responses. Therefore, they had offered a prize draw in 2016 as an incentive for people to complete the questionnaire.

The registered manager had notified the Care Quality Commission of events which had occurred in line with their legal responsibilities.