Care Quality Commission

Manchester City Council

Manchester Disability Service

Inspection report

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Ratings

Overall rating for this service	Good
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?	Good

Overall summary

The inspection took place on 24 and 25 February 2015. We gave 24 hours' notice before the first day of the inspection. The previous inspection of Manchester Disability Service had been on 30 January 2014 when we found the service was meeting legal requirements.

Manchester Disability Service is run by Manchester City Council to provide care for people with various kinds of physical disability and degenerative illness. The people using the service, who are referred to as customers[KL1] , rent their own flats or bungalows. The service provides assistance with their personal care in one site in Chorlton in south Manchester where there are 22 flats and two shared bungalows for four or six customers respectively with more complex health needs. There are three sites in the north of the city with altogether 21 bungalows for one or two people.

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.

Summary of findings

We found that the service provided personalised care for the individuals they were supporting, who had a wide range of needs. The environment was safe, but we found that the use of a mobile warden service at night on one of the sites was not satisfactory and required improvement.

There were ways in which the environment in some of the sites could be made more sociable in order to reduce isolation.

We found that the service applied the Mental Capacity Act 2005 and obtained people's consent where possible, but that there was some uncertainty from the providers as to whether and how to apply the Deprivation of Liberty Safeguards.

Some people benefited from a range of activities, but that was not true for all. Meetings were held at which customers were informed about any changes and could express their views.

The service had a good management structure. We were told about imminent changes which had caused some uncertainty amongst staff, but were now about to happen. The service conducted effective audits. There were a number of notifications which should have been submitted over the course of the year but we had not received.

Summary of findings

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 consistently safe.

The safety of customers was taken seriously and the environment was designed to protect them from risks.

Staffing levels were sufficient in the day time. On one site there was no staff presence at night, and people had access to a mobile warden service. However, we found an example where the warden service had not responded to a customer who was at risk.

Medication was administered safely. Staff had been trained in safeguarding vulnerable adults and incidents and allegations were investigated and dealt with effectively.

Is the service effective?

Good

The service was effective. Staff received relevant induction and ongoing training, and supervision. Agency staff were also used, who did not receive training from the service.

The principles of the Mental Capacity Act 2005 were being followed, and where possible consent was obtained for any restrictions. The service was also using a tool to check whether there were any deprivations of liberty, but not always effectively

People were supported to have regular health checks and to eat healthy food.

Is the service caring?

Good

The service was caring. People told us they felt well looked after. Their needs varied but the service adopted ways of caring to meet people's changing needs.

People were involved in planning their care and support, and in their living arrangements. There was a high level of satisfaction with the care provided.

When needed, support was provided at the end of life, enabling people to stay in their homes if they wanted to.

Is the service responsive?

Good

The service was responsive. Care files were personalised, meaning that they recorded and responded to each person's individual needs.

Some people were engaged in meaningful activities, but this was not the case for all. We observed a lack of communal space in some of the accommodation.

There were tenants' meetings which allowed people to express their views and preferences. There was an effective system for handling complaints.

Summary of findings

Is the service well-led?

Good

The service was well led. There was an effective management structure, although we learnt that the provider was about to change the management arrangement for this and other services.

Internal audits were completed. The provider was not conducting external audits as in previous years.

Team meetings were held regularly. Some required notifications had not been received by the Care Quality Commission.

Manchester Disability Service

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.

The inspection took place over two days, on 24 and 25 February 2015. We gave 24 hours' notice before the first day of the inspection. This was because we were visiting people in their homes and needed to let the staff know we were coming.

The inspection team was led by an adult social care inspector. They were accompanied on the first day by a specialist adviser, a nurse who had experience of working with people with acquired brain injuries.

Prior to the inspection we reviewed all the information we held about the service, including notifications received from and about the service since the previous inspection.

On the first day we visited two of the sites in north Manchester. We talked with five people in their bungalows. We met with the manager of the North projects (as the sites were called) and four care staff. We examined four care records in detail and looked at other records. On the second day we visited the main office in Chorlton south Manchester. We talked with three people living in one of the shared bungalows. We talked with the registered manager and with three care staff. We looked at one care record, staff rotas and three staff personnel files. We obtained copies of documents relating to training, supervision, audits, questionnaires, complaints and staff meetings.

Requires Improvement

Is the service safe?

Our findings

Not all the customers of Manchester Disability Service were able to communicate with us effectively, but where we could we asked them whether they felt safe. No-one said or indicated that they felt unsafe. One person said "Yes I feel safe. Staff have never made me feel unsafe." They added that they had the same staff every day, which made them feel more secure. Another person said: "I have never felt unsafe, not at all. I would tell someone if there was a problem." In customer questionnaires carried out in November 2014 in the northern sites and the Chorlton site respectively, 88% and 90% of people stated that felt safe where they were living.

Staffing levels in each of the sites were matched to the needs of the customers. On the northern sites with bungalows there was at least one member of staff on duty on each site from 7.30am to 9.30pm. Staff sometimes worked long shifts. For example one member of staff was working from 12 noon to 11pm, followed by a sleep-in shift till 7am and then working 7am till 12.30pm. They said that it was rare for them to be disturbed at night, but if they were they could ask to be relieved the following morning.

At the Chorlton site there was one customer who needed round the clock support. These staff worked 12 hour shifts. We learnt that the staff providing this support were agency staff but that they were working regularly and had got to know the customer well. This was confirmed by the agency member of staff on duty during our visit and by the customer.

At one of the northern sites there was no staff cover at night. At our two previous inspections in February 2013 and January 2014 we had reported on the change to using a mobile warden service. We stated that careful monitoring was required to find out what happened when a warden was called, in terms of the speed and the quality of the response. At this inspection we saw records showing that customers had been carefully assessed as to their ability to understand the warden service and to use a pendant alarm to call them when needed. In another of the sites overnight staff were still in place because of the perceived needs of the customers.

We asked how the warden service was working in the site where it was used. We saw a record was kept of the times when the service had been called. On receipt of a call the service would either send out a warden or call an ambulance.

We were informed about an incident a week before our inspection. No notification had yet been submitted, but this was done at our request. A customer had fallen out of bed at about 12.30am and required assistance to get back into bed. Using their pendant alarm they called the warden service, who requested an ambulance which attended 22 minutes later (the customer next morning reported the wait had been much longer, but the ambulance service recorded the time they attended). The customer was helped back into bed, cold but uninjured.

Staff from the service questioned the warden service about the service received, and why an ambulance had been sent. The reply was that it had been an extremely busy night for the warden service and at the time the call came in the two response officers (i.e. the wardens) were out in the vehicle on another call.

Clearly if staff had been present on site then the customer would have had to wait much less time before being helped back into bed. If they had suffered an injury then the delay might have been significant. Moreover there were issues about the effectiveness of the mobile warden service if they only had one car available during the night to respond to calls.

One other customer told us that they did once ring for help in the night, which had according to them taken a long time to arrive. However, the record showed that the response had been quite quick.

We discussed these issues at some length with the manager of the northern sites and with the registered manager. One suggestion they made was that the warden service should be given a contact number for local staff who had expressed willingness to attend during the night. They also suggested that a longer term solution might follow a planned reorganisation of the service, which would entail more staff being present on site overnight because of the needs of new customers.

We saw that the service was anxious to ensure that the warden service met the needs of its customers and ensured their safety. Following the recent incident where the warden service had sent an ambulance, Manchester

Requires Improvement

Is the service safe?

Disability Service had responded proactively by challenging the warden service to explain its actions, and by planning changes to reduce the possibility of a similar incident recurring. Nevertheless, we considered that the current arrangements were unsatisfactory and the service required improvement in this area.

We saw that all the customers we met were living in a safe environment which was adapted to their needs and capabilities. Customers had furniture which was suitable and unlikely to be a hazard. People using wheelchairs were living in bungalows where the physical risks of moving around were reduced to a minimum, by the careful choice and location of furniture. They were able to leave their bungalows if they wanted, and some had doors which they could safely open remotely from inside. The block of flats was about to be fitted with a new lift as the previous one had been breaking down occasionally. Arrangements had been made for some people to find alternative accommodation during the period of the lift repairs, to avoid risks to their safety.

We knew from notifications received that safety matters were taken very seriously. Disciplinary action had been taken against staff when they were perceived to have acted in an emergency in a way that did not best protect the safety of customers. We saw the outcome of this disciplinary action and that it had been explained very clearly to the staff where their actions had fallen short. This was likely to prevent a recurrence in the future. The senior manager hearing the case also found that the emergency evacuation plans needed to be revised in order to ensure certainty about which staff were responsible in an emergency; this had been done.

A fire protection officer had on 19 January 2015 done a comprehensive inspection of the south Manchester site. We saw their letter confirming that the site was compliant with fire safety regulations. All staff were trained in fire evacuation, and each person had a personal emergency evacuation plan which had recently been updated.

Staff were trained in safe medication administration. The training was repeated every three years and we saw records showing that the training was up to date. We saw the results of a detailed medication audit carried out in December 2014 which had not identified any problems.…

A monthly Medication Administration Record (MAR sheet) was used for each customer. This recorded the amount of each medication given and the quantity remaining. The MAR sheet was signed by the member of staff and checked by a second member of staff. This provided a means of assuring that medicines were administered correctly.

Medication was stored safely. People living in flats had lockable cabinets. Staff would assist some customers by getting the medication ready for them to take. Others were able to self-administer, in some cases after prompting. In the communal bungalows medicines were kept in separate baskets securely in cupboards, labelled and with a photograph of the customer. In previous years there had been a number of medication errors which had been dealt with effectively by the registered manager. Since the previous inspection we were not aware of any problems with the administration of medicines.

All staff had received training in safeguarding vulnerable adults as part of their induction and on an ongoing basis. We spoke with staff who confirmed this and saw training records. Safeguarding and the need for vigilance were discussed regularly at team meetings. We saw minutes of meetings which confirmed this. The staff we interviewed were familiar with the various kinds of abuse that might potentially arise in a supported living setting. They knew how to report it and who to report it to, but said they personally had not had any cause to report anything while working with Manchester Disability Service.

We knew from notifications received during the year that there had been a number of safeguarding incidents and allegations. The registered manager usually reported these to us promptly and kept us updated as to the outcome.

We asked to see records relating to the recruitment of the latest three members of staff. We looked at their personnel files which included records of their induction and probation, and of their training. There was evidence of a check with the Disclosure and Barring Service (which would disclose and criminal convictions or cautions). However the records relating specifically to recruitment, namely copies of their application forms, interview records and references, were kept centrally by Manchester City Council and were not available for our inspection.

Good

Is the service effective?

Our findings

One customer said to us: "I like the staff. They know exactly what to do. In the morning they help me get up and take a shower, then they give me breakfast. The staff know me and know what I need." Another person told us that they didn't have any concerns regarding their care and support.

One support worker told us that they received regular ongoing training, some in face to face sessions and some via e-learning (i.e. study on the Internet). They said that staff could put themselves forward for specific training courses. For example they had requested training in epilepsy and had received this.

We saw records of all the training received by staff in the south Manchester site. Staff received training in all the essential areas. This included basic training in resuscitation, moving and handling, managing challenging behaviour and breakaway techniques. Some staff had received training specific to the needs and health condition of the person they were supporting. One of the office staff told us it was their responsibility to ensure that staff were up to date with their training and received refresher training when it was due. They explained that sometimes the training courses were not available, for example two new support staff had started work in June 2014 but had not been able to attend moving and handling training until September 2014 because it was not made available by the provider. This meant that the new staff had been unable to act fully as members of the team, which had been confusing to customers because the staff could not help them.

We became aware that Manchester Disability Service regularly used agency staff, including some who routinely supported one customer around the clock. We spoke with one agency support worker who had worked there three times previously. They explained that they had met the regular staff and read the care plans of the people they were supporting. They said they had received relevant training from their agency in medication, health and safety, physical intervention, moving and handling and safeguarding. They said: "I am confident I am equipped to deal with the people here."

However, the service had less control over the training of agency staff then they did for regular staff. We saw in the minutes of one team meeting that staff had asked: "Have agency staff had all the appropriate training as regular staff sometimes feel some do things that aren't right?" The registered manager told us that after the end of a recruitment freeze the service had within the last year recruited three support workers but there were still vacancies. This made necessary the continuing use of agency staff who might not be as well trained as regular staff. However, many of the agency staff worked regularly with the service so that customers got to mow them well.

Staff told us they received regular supervision (called 'job consultation') and we saw records of the dates. One support worker told us they had job consultation every six to eight weeks. Their line manager wrote the agenda, but they were able to add to it before and during the meeting. Then a copy of the outcome of the meeting was kept on their file. At previous inspections we noted that annual appraisals had not been conducted, and then that they had not been recorded individually. We now saw records to show that all staff were receiving annual appraisals, which were being recorded on their individual files.

Staff were trained in the Mental Capacity Act 2005 (MCA), with the exception of three staff who had started in the summer of 2014 who had not yet received training. Four members of staff were overdue their refresher training. We saw evidence that the principles of the MCA were applied. For example padlocks were placed on the fridge and freezer doors in one customer's bungalow. We saw a mental capacity assessment made by a social worker to assess the customer's capacity to consent to that practice. The customer had given valid reasons for the padlocks to be present, and the assessment was made that the customer did have capacity to consent. This showed that Manchester Disability Service followed correct procedures in the MCA to ensure that the customer was consenting to what otherwise might be seen to be an infringement of their liberty.

In another case a customer had been assessed as having the capacity to consent to wrist restraints which were designed to present then harming themselves. The customer's consent to the restraints was obtained and recorded.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS. The Deprivation of Liberty Safeguards (DoLS) are part of the

Good

Is the service effective?

Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

An 'Individual Scale Tool' had been employed to assess whether customers were being deprived of their liberty. We were told this tool had been used at the request of the provider. The principles of the MCA and DoLS were relevant in determining whether a customer was subject to a deprivation of liberty and therefore their rights might need to be protected.

We noticed that the Individual Scale Tools had not all been completed correctly. In some cases the assessor had decided that the customer did have capacity to make a decision, in this case whether to remain in the accommodation. That being so, the next stage of the form, namely whether the customer was being deprived of their liberty, should not have been completed.

We discussed this with the registered manager who emphasised that the form was simply a screening tool and that no decisions had resulted from it. However, in one case the Individual Scale Tool had been passed to the DoLS team of Manchester City Council for them to decide whether a formal application under DoLS needed to be made.

We saw evidence of regular health checks at the dentist, optician and chiropodist. One person told us: "They take me for appointments to my GP and the hospital. They look after my health, and make sure I take my medication." On one care file we saw feedback forms completed after each visit to the GP by the member of staff who accompanied the customer This meant that the staff were keeping accurate records about customers' health.

The arrangements for food varied according to people's circumstances. Some people were able to cook for themselves; others needed staff to cook for them and help them eat. One person told us: "They usually ask me what I want to eat when planning the menu. The food is not too bad. They try and vary it. There is always fruit."

Care plans contained information on healthy eating and individuals' dietary needs. People's meals and drinks were recorded on their care files. The house audit in each bungalow included checks to ensure that food was being stored safely, and in one case recommended that the cooker and cutlery trays needed cleaning. This would help ensure that health was maintained.

Good

Is the service caring?

Our findings

The organisation's Statement of Purpose (a document that every provider must produce) set out what it calls a "Dignity Charter". This stated: "We want to ensure that every person we support is treated with dignity and respect."

People who talked with us said that they felt well looked after by the staff at Manchester Disability Service. One person said: "The staff are helpful. They are always doing things for me." Another person said: "They take care of me and are my friends." A third person said: "The staff understand my condition and needs, and I don't have any concerns regarding care and support." One of the induction training courses taken by all staff was called "Supporting healthy active lifestyles".

Extensive pre-assessments were made to ensure that a potential new customer would be suitable and that their needs could be met. We learnt that when a new customer moved in either to one of the bungalows or a flat, a member of staff was assigned to look after them and help them settle in. The member of staff would request the involvement of extra staff if needed.

People were informed about their care and living arrangements in a way appropriate to their level of understanding. We saw several care files where customers had signed documents, including their tenancy agreement. Staff told us they explained the purpose of the agreement so far as was possible. This meant that the customer was involved in the arrangement. People who were able to also signed their support agreements, which were a statement of what support would be provided. One of the aims of the service, set out in the Statement of Purpose, was to "support people to make decisions and have control over their own lives, whilst offering a safe place to live and thrive within their own setting and aspire to grow and develop their skills." Our observation was that staff were seeking to develop this aim, where they could.

For example, one customer told us they had recently been approved to have a personal assistant (PA). Staff told us the service had been instrumental in arranging this. The customer said they were excited about having someone who could take them out. "I have decided I like this person" they said, "I think it will improve my life." This would increase their wellbeing.

At a tenants' meeting in one of the northern sites there was a discussion about respect and dignity; all the customers had agreed that staff knocked on doors before entering. We observed staff engaging respectfully and positively with people while promoting choice in relation to their personal care. Staff explained what they were doing before they did it. Customers told us that they were consulted and involved in planning their own care and support.

Questionnaires carried out in November 2014 asked customers how well they felt they were treated, both by staff and by other customers. In the northern sites 100% of people answered either "excellent" or "good". The figures were lower on the Chorlton site (75% responded either "excellent" or "good"). Some of the people at the Chorlton site had high needs.

The nature of some customers' disability and/or illness meant that they were on an end of life pathway. Part of the philosophy of care was to provide for people's needs all the way to the end of their life. We knew from death notifications that the service put this into practice and enabled people to stay at home as long as they wanted, and where possible to die in their bungalow or flat. We saw that staff arranged with doctors to provide the necessary paperwork to enable people to receive the palliative care they needed. District nurses and Macmillan nurses attended as needed.

Is the service responsive?

Our findings

The Statement of Purpose states: "We will provide individualised person centred support… Personalisation is the focus of our support." This meant that care and support would be designed to match the needs of each individual.

Each customer had a care file containing a personal record system, a daily file and a health action plan. We saw evidence of joint decision making; some customers had recorded their wishes within the care plans. All aspects of activities of daily living were documented and up to date. There was a section headed "goals, aims and objectives" which had been completed together with the customer.

Since our previous inspection one person had been supported to obtain voluntary work in the same industry they had worked in before their disability; there was a cutting on the care file from a regional newspaper celebrating this achievement. The service had developed a risk assessment covering the customer's participation, including them travelling independently to and from the workplace.

Customers who had the benefit of a PA could go out on trips with them to places of their own choosing, which included shopping, swimming and horse riding. This type of activity was not available for all. On one of the northern sites support staff stated that some of the customers spent most of their day watching television, despite being offered opportunities to attend local day centres.

The individual bungalows in the northern sites were comfortable and homely, equipped with people's own furniture. However, the environment lacked the opportunity for social integration. The customers we spoke with indicated a high level of loneliness. One person said: "I do feel lonely. It is better in the day but at night there is no-one around." The layout of the garden in one of the sites emphasised the seclusion, with fenced off areas for each bungalow which would prevent anyone sitting together. We mentioned this to the registered manager, who acknowledged the design of the garden was not ideal. Staff did say that in the summer they had occasional barbeques.

In another of the sites there was a communal room, but this tended to be used by the staff. We learnt that the room was now used for people to share a "Friday night takeaway" for those who wanted.

By contrast in one of the shared bungalows on the Chorlton site there was a living room shared by all the occupants. Here one person told us that they interacted with other people in the bungalow. We saw that this was true for some of the people living in the bungalow, who were mobile. This helped to reduce social isolation and improve their quality of life. Some people were not able to leave their bedrooms because of their health condition.

We looked at one person's care file when the person themselves was unable to communicate with us. It was clear that the staff worked hard to optimise the customer's quality of life. The customer was supported to take part in cooking, walking to the shops, and other activities. Risk assessments highlighted potential dangers. The staff involved the customer wherever possible in decision making about activities and the risks involved.

One customer told us they typed up minutes after meetings with other customers in the adjacent bungalows. These were known as tenants' meetings. They told us: "It gives me something to do."

These tenants' meetings took place every quarter. One customer told us the meetings were "useful". We saw the minutes of the last two meetings on the Chorlton site. Judging by the minutes, the meetings were primarily used to pass information on to customers, although they were also an opportunity for customers to raise any issues. At one of the meetings customers chose the colour scheme for the inside of the new lift which was due to be installed. The customers had also suggested that a door connecting one of the bungalows to the office should no longer be used by staff as it meant people were passing through their living space, and this had been agreed by the registered manager. This showed that the customers were listened to.

There was a complaints policy produced by the provider. Each customer and/or their representative had a leaflet about how to make a complaint. The registered manager showed us record of complaints since our last inspection. Each complaint had been investigated and a response made by the service. In one case action had been taken to prevent a recurrence. One customer had been assisted to make their complaint in writing to the council. There was no recurrent theme to the complaints. The registered manager had recently attended a course on "Effective complaint handling" run by the Local Government Ombudsman.

Is the service well-led?

Our findings

One customer we spoke with gave positive feedback of the whole staff team. They commented that they felt the staff had a good insight into their condition and needs. We observed that the staff worked hard as a team to optimise the customers' quality of life. Staff morale appeared positive and staff were comfortable discussing various aspects of the service and their professional role. We saw that staff had a very good rapport with the customers.

The registered manager of Manchester Disability Service was at the time of our inspection responsible for the Chorlton site and for the three sites in North Manchester. There was also a manager of the northern sites, and care co-ordinators who moved between the three sites. The northern manager told us that they had sufficient autonomy to run the sites without constant reference back to the registered manager, and that they felt supported and would consult the registered manager on any significant decisions.

We were informed of changes to the operation of the service being implemented by the provider. These had caused a period of uncertainty for the staff. The registered manager explained that staff had been kept fully informed and consulted.

In previous years 'Quality validation visits' were conducted by officers of the provider, Manchester City Council, who reported on assessment of customers' support needs and support planning, safeguarding and customer involvement. These visits had not taken place since our last inspection. This meant there was less external checking of the operation of the service, but the registered manager showed us the results of internal audits. For example there was a 'house audit' every quarter which checked the communal areas and bedrooms in the shared bungalows. The auditor in December 2014 made a number of recommendations, particularly in relation to the kitchens. They checked the paperwork, for example the staff rota, the handover file (used by staff to record events on their shift to pass to the next staff) and financial records. There was also a detailed medication audit. We saw that actions identified in the December house audit had been followed up by the registered manager and a care co-ordinator in January 2015. Spot checks had been introduced to supplement the quarterly audits. This meant that there was an effective system of internal audit.

The registered manager maintained a checklist of paperwork in people's care files to ensure all the documents were present and up to date. She showed us that she had redesigned the Medicine Administration Record to include the time of administration. This followed an observation made by a CQC inspection of a related service run by the same provider. This demonstrated a proactive approach to improving service delivery.

Team meetings took place regularly, for the staff who worked on each site, in the flats or in the shared bungalows. There was also a meeting for night staff. We saw that the minutes were signed by all staff. By attending these meetings staff were all kept fully informed of issues and the changing needs of customers.

We asked a support worker what were the values of the service. They replied: "To provide the best possible care and to make sure people are safe and happy."

There were some examples of events which had not been reported to the CQC, but should have been. One was a safeguarding raised about a customer being taken to the GP without the appropriate details; this had been substantiated. Others were an accident outside the premises, where the customer had sustained minor injuries, and two complaints involving allegations of abuse of different kinds, which had not been notified to us. One death notification had been sent stating the customer's previous service address. We discussed with the registered manager the requirement to submit notifications to us in a timely manner. The provider used an encrypted method of transmission which meant that some notifications had failed to arrive.