

Mencap in Kirklees

Mencap in Kirklees (DCA)

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Good ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

The inspection took place on 28 July and 3 August 2016 and was announced. The last inspection of the service was in January 2014 and was compliant with the regulations at that time.

Mencap Kirklees DCA is registered to provide personal care to people in their own homes. There were 19 people receiving personal care at the time of the inspection.

There was no registered manager in post at the time of the inspection, but there was an interim manager in charge whilst a new manager was being recruited.

People felt safe and staff demonstrated understanding of safe practice. Procedures for safeguarding people were in place, although lacked full detail about what staff should do to report any concerns other than internally.

Risk assessments identified each person's risks, although these were not always updated following significant incidents, such as choking or falls.

Recruitment procedures ensured staff were vetted and their suitability to work with vulnerable people was checked. Staffing levels were supportive of people's needs.

The interim manager identified weaknesses in medication management and was taking steps to improve this.

Staff had opportunities to update their skills and professional development. Staff demonstrated an understanding of the impact of the Mental Capacity Act (MCA) 2005. There was work being done to improve the quality of the recording of people's mental capacity assessments.

People told us kind and caring staff supported them and relatives said staff were professional in their approach.

Staff worked well together and felt supported by managers and the organisation, with recent improvements reported to us by staff about the management of the service.

Care records contained information covering all aspects of people's individualised care and support, with details easy to locate, although some records lacked detail and were in the process of being reviewed. Daily notes about individuals' care were maintained but not promptly brought into the office for reviews.

People felt supported to complain if they were unhappy about any aspect of their care and there was plenty of information for people to understand. The complaints record did not always illustrate the detail or the outcome where complaints had been received.

There were developing systems for auditing the quality of the provision and the interim manager had identified the strengths of the service and devised an action plan for the areas to improve. There was an open and transparent culture in which staff felt able to approach managers.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Risk assessments were in place but not always updated following incidents.

Staff were confident in their knowledge of how to ensure people were safeguarded against possible abuse, although the written procedure lacked detail.

Systems were not thorough enough to ensure medicines were managed safely.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were given choices in their daily routine and their consent was sought in line with legislation and guidance. Staff understood the principles of the Mental Capacity Act (MCA) 2005 and there were improvements ongoing to the recording of people's mental capacity assessments.

Staff had regular access to relevant training to enhance their role and felt supported to undertake professional development.

There were improving systems in place to support staff through supervision.

Requires Improvement ●

Is the service caring?

The service was caring.

People told us staff were kind, patient and respectful in their approach.

Staff were enthusiastic and passionate about delivering a caring service.

There was respect for people's privacy and dignity, with a designated dignity champion promoting people's rights.

Good ●

Is the service responsive?

Good ●

The service was not always responsive.

People's individual preferences were considered in the provision of their care and there was evidence of person centred planning.

Care plans lacked some detail, although there was a clear plan being implemented to review and update these.

People understood how to make a complaint and the complaints procedure was readily accessible. The outcome of some complaints was not always clearly recorded.

Is the service well-led?

Requires Improvement ●

The service was not always well led.

Systems were in place and being further developed within the organisation to regularly monitor and review the quality of the service.

Communication between staff in all roles was clear. However, there was no robust system to alert the office if a visit was missed.

Documentation to support the running of the service was in place, although lacked attention to detail at times.

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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 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 took place on 28 July and 3 August 2016 and was unannounced.

There was one adult social care inspector. Prior to the inspection we reviewed information from notifications sent to us by the provider and we contacted the local authority. The provider had sent a Provider Information Return (PIR) with information about the service.

We spoke face to face with two people who used the service and we spoke with four relatives over the telephone. We spoke with one member of care staff and three of the management team in person and two further members of care staff over the telephone. We also reviewed three people's care records and documentation to show how the service was run.

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person said: "Yes I know I'm safe. If I don't feel safe I can talk to the staff. I don't like it when strangers I don't know come to my house but the staff know me very well and I'm always introduced if anyone new comes". The person told us they were aware of their individual risks and how to manage these with support from staff. The person said: "The staff are all brilliant, one of them [staff's name] goes over and above and I get good support; that makes me safe". Another person said: "I do feel safe, I have safe care". One relative we spoke with said: "My [family member] is safe always, I have 100% confidence and I have no qualms about their safety. Everything is as safe as it can be". One relative said: "I think [my family member] is safe, they haven't used the service long but I have a gut feeling".

Staff we spoke with had a good understanding of the individual risks to people. One member of staff told us they knew who had particular risks, such as choking, and what to do if an incident occurred. We saw care records highlighted where there were individual risks, although when we looked at the accident/incident records we saw individual risk assessments had not always been updated following an event. For example, one incident report showed a person had been choking on their food, and another person had fallen, yet their risk assessments had not been updated following these incidents.

Safeguarding and whistleblowing policies procedures were in place and known by staff. The safeguarding procedure lacked detail for staff to report concerns to those other than internally, although staff we spoke with knew who to contact. Staff understood the possible signs of abuse and were confident to report any concerns to line managers and to the local safeguarding authority where necessary. Staff were aware of techniques to use to de-escalate potentially harmful situations and to report any incidents, with referrals to safeguarding as required. Staff we spoke with said positive techniques were used in routine situations to support people's behaviour.

Accidents and incidents were recorded and systems were in place to analyse these quarterly to establish where trends or patterns occurred, for individuals and the organisation. Information from incidents was not always transferred to people's care plans or personal risk assessments.

The interim manager said people's medicines were available in dosette boxes, with prompts given by support staff, although there was limited recording of this aspect of people's support. All staff had medication training and the interim manager was making a start on completing competency checks. The interim manager said staff competency was not currently assessed in relation to managing and administering medicines and there had been a lack of clarity regarding the difference about what was administering and what was supporting medicines. The interim manager had identified this as an area to improve. There was clear documentation in people's care plans about the medicines they required and the people we spoke with told us staff reminded them to take their medicines.

Staff recruitment procedures were robust to ensure all those working with vulnerable people were suitably vetted. We looked at two staff recruitment files. We found safe recruitment practices had been followed. For example, reference checks had been completed from two referees and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the

risk of unsuitable people from working with vulnerable groups.

Staffing levels were appropriate for the needs of people, based upon people's individual needs and accounted for people's preferences in the activities they undertook. For example, one person's care record showed they liked to go out to social activities and appointments and would need the support of staff to do so. The person and members of staff confirmed staffing levels always enabled this to take place. We discussed the staffing levels with the group manager who told us they had sufficient staff, with a bank of support staff who were familiar with people's needs, limiting the need to use agency staff. People's needs were matched to relevant care staff where possible and care was taken to ensure the balance of male and female staff to support as required. Managers also supported staff by covering shifts where necessary.

Staff rotas were being revised with a new system using information technology about to be introduced. Communication about this was shared with staff at staff meetings and reassurance given that staff would receive training on the new system. There had been no recorded missed care calls to people but there was no system for alerting managers if staff did not turn up or were late, other than people contacting the office. The management team acknowledged this was an area that could improve as some people were particularly vulnerable and may not be able to alert the office to a failed call.

Is the service effective?

Our findings

People told us they thought staff knew how to do their jobs. One person said: "The staff are great, they do the job just right." Staff we spoke with said they thought people received care from staff who had the right skills and abilities. One relative we spoke with said: "There's a good mix of staff ages and they have an appropriate manner and attitude".

Staff who were new to the service described a gradual and thorough induction and we saw evidence of this in staff files we looked at. One member of staff told us they had been given time to get to know people before supporting them. Staff files we looked at showed staff had signed to say they had read the policies and procedures and staff we spoke with said they knew where to find these. Staff all reported teamwork being very good and said they felt valued as a member of the team.

Staff said they felt supported to undertake their work and complete relevant training. The training calendar for 2016/2017 showed expected and additional training and which members of staff had undertaken these. Staff had completed training in areas such as infection control, safeguarding, moving and handling, pressure care, medicines, fire safety, distraction and intervention and dignity. Staff praised the training and said they felt supported to develop their skills. One member of staff said training had been rescheduled for them when they could not attend and there was variety in the opportunities available to staff. We saw from records staff were working towards the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The Skills for Care induction is designed to provide a structured start for new employees to help ensure they are safely able to provide support to people. This helped to ensure staff had up to date skills to enable them to provide effective care and support to people.

The interim manager told us staff engaged with their line managers in supervision meetings, although there were plans to increase the consistency of this support and said this was an area to develop. Staff said they had supervision, but not all staff said this had been regular in the past. Staff we spoke with said the communication with managers was very open and effective, and they felt able to raise any issues at any time. The management team said they monitored staff suitability through observing them in their work and staff we spoke with confirmed this.

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.

The interim manager told us not all of the people who used the service had capacity to make their own decisions and consent to the care and support provided, and they understood their responsibilities under the Mental Capacity Act, should anyone lack capacity. When we asked staff, they also demonstrated an understanding of the principles of the MCA.

Our discussions with staff and people using the service showed consent was sought and was appropriately used to deliver care. People we spoke with who used the service said they were able to express their views and make decisions about their care and support. Staff we spoke with said they encouraged people to make their own choices and they provided care and support with consent from the person. Staff also said they encouraged people to be as independent as possible and people we spoke with confirmed this. One person said: "The best thing is my independence". They described how staff had supported them to choose curtains and furnishings for their new flat.

In some of the care files we looked at consent had been obtained for key areas, such as photographs, medicines support and advocacy and there was evidence the care plan had been agreed and reviewed with the individual, although not all aspects of the care agreement had been signed. Staff we spoke with said they were asked to speak with each person about each aspect of care and consider if they had understood, retained, weighed up the information and been able to communicate their decision, along with staff explanation for what was recorded.

In some people's care plans the recording of mental capacity was clear and decision specific, such as for finances, personal care and using photographs. Where advocacy service was required some steps had been taken to make sure this was available to people, but there were gaps in the recording of this.

Is the service caring?

Our findings

People and relatives told us staff were caring. One person said: "They care, I like that". Another person said: "They [the staff] do more than they have to, that's how I know they care". A relative said: "Staff are lovely". Another relative said: "They get 10/10 for caring". Another relative said: "I am completely relaxed knowing how caring the service is".

Staff we spoke with all said they would be happy for any of their own family members to receive support from the service. Staff were passionate and enthusiastic about their work with people. Comments from staff included: "It can be a long day, but gosh, it's worth it", "I put a smile on somebody's face every day; I feel I am making a difference"; "There are too many best things about the work I do" and "If they're happy, I'm happy".

Staff encouraged and supported people to speak in an open and honest way and to share their views with the inspector and enabled them to do this in private. People told us they felt staff showed them respect and were aware of the need to allow them privacy in the way they were supported.

Some people had a diagnosis of Autistic Spectrum Disorder (ASD). We found staff were aware of some people's need for routine and this was reflected in their care plans and in the way staff spoke about their personal care delivery. One relative we spoke with gave praise for the way staff enabled their family member to maintain their important routine. They told us: "[My family member] likes their own routine, routine is very important and staff know this".

There was a designated dignity champion whose role was to promote people's dignity and rights within the service and to increase awareness. We saw information displayed about 'Dignity Dos' in the service and we saw from staff meeting minutes dignity was routinely discussed within teams.

Staff were respectful of people's rights. The group manager informed us where some people had requested the content of their care plans not be viewed by anyone other than staff providing care this was respected. People were aware of confidentiality. One person told us "I've seen my own care file but I'm not allowed to see anyone else's, that's theirs and it's private".

Care records were written in the first person and showed people's cultural, spiritual and religious needs were considered. There was a clear support overview for each aspect of people's care and a pictorial contract in place to show which aspects of support were discussed and agreed. Care records highlighted signs to be aware of or triggers that may make a person feel anxious, with information for staff about how to help people manage stress. Staff we spoke with said they had read people's care records and knew the level of support and reassurance to give.

When supporting people with their care, staff told us they offered good explanations to enable people to do as much for themselves as possible. One person told us: "My condition means I need support for certain things and that's why I need the service at Mencap. But the staff always help me do as much for myself as I

can, that's really important to me".

Is the service responsive?

Our findings

People we spoke with said the care provided was responsive to their needs. They told us they were aware they had a care plan and knew staff made notes to update this. Relatives said staff were approachable. One relative said "I don't think there could be a better place for [my family member]."

All staff we spoke with had a good understanding of the individual needs of people. Staff were able to describe people's personalities, their likes and dislikes and their individual care needs.

Staff understood what mattered to the people they supported and told us how they ensured their well-being. For example, one person enjoyed going on holiday with a particular member of staff, so the staff member facilitated this.

We looked at three care plans and saw each care plan was individually tailored to reflect people's needs. Whilst we saw care records gave personalised information of how people needed to be supported, the interim manager told us they were improving the level of detail.

Daily notes were maintained illustrating the care each person had received. There was evidence of people's choices being promoted, such as if they wished to go to the hairdresser, cafe or appointments. Details of people's personal care requirements were noted on their records for staff to be able to give the right level of support. Daily notes were brought to the office on a monthly basis, although the interim manager had identified these needed to be more frequently brought in, to be reviewed and monitored to identify whether any trends, patterns or safeguarding matters occurred and make sure care was responsive to people's needs.

There was an up to date service guide which contained easy read, pictorial information for people to understand. People were informed of current issues, such as changes to the management team through an informative newsletter written in simple language, along with a questionnaire to gather people's views. The Mencap newsletter was issued monthly and relatives we spoke with confirmed they had seen this. We saw questionnaires were given to staff and people, with easy read/response formats available. Relatives we spoke with said their views and opinions were taken seriously.

People and relatives we spoke with all said they knew how to make a complaint if they were unhappy about the service. One relative we spoke with said they would know how to complain, but said they could not think of why they would need to. One relative told us if their family member was not happy in the service they would make their views known. Relatives said they felt well informed about their family members' care and support.

We saw there was a clear and detailed complaints procedure information available in the service to assist people. This was in easy read format, with photographs of the staff people could voice any concerns to. Staff we spoke with said they would ensure people's views were heard and should people have cause to complain, staff said they would support them to follow the procedure. There was a system in place for

recording complaints and compliments, and although it was not always clear from records what the outcome of complaints had been, there were plans to improve this.

Is the service well-led?

Our findings

There was no registered manager in post at the time of the inspection, because they had recently left the service. There was an interim manager in post and the service was actively recruiting for a new manager.

Staff, people and relatives we spoke with told us they felt the service was well run, with reference to the recent changes in management resulting in improvements. Staff said they were initially unsettled due to recent changes, but quickly became reassured with the appointment of the new group manager and the interim manager. Staff said the group manager and interim manager had 'really made a difference' and the Chief Executive was 'jolly' and 'up front'.

The interim manager said they had been in post since June 2016 and had carried out a 'mini-inspection' to assess the strengths and weaknesses of the service. A service improvement plan had been drawn up to address areas requiring improvement with timescales for completion. This identified issues in relation to mental capacity, notifications to CQC, staff training and support, quality of audits and documentation. We saw evidence of the service improvement plan being implemented and action taken, with high levels of action during July 2016.

We saw the interim manager had begun to carry out audits of care records. Some issues had been identified and work was being commenced improve these, although there were still some to complete. The interim manager explained they were working through these one at a time in order to be thorough and set the standard for staff to be able to maintain.

We discussed with the interim manager there had been a lack of statutory notifications sent to CQC. This had been identified and the interim manager had discussed this with the senior managers in order to make improvements going forward. We saw notifications had improved since the interim manager came into post, which evidenced improvements to this aspect of the management of the service.

The values and vision of the service were available and known by staff who told us they felt confident in their roles and responsibilities. Staff understood who was in charge and said the management team encouraged staff to raise any concerns with them at any time should they need to.

We found there was open and transparent communication in place, with effective communication to staff, people and relatives about the changes in leadership. Where the service improvement plan identified areas to improve these were discussed openly with staff. For example, new case files for people were shared with staff at meetings.

Staff meetings addressed operational and professional matters, such as health and safety, the planned new rota system and news and documentation. Staff we spoke with said they felt able to contribute to staff meeting discussions. We saw staff meetings had been held in July 2016 and gave consistent messages to different groups of staff. Staff meeting agendas included 'news and views' in which any current matters were raised. Minutes of staff meetings recorded staff had been thanked for their commitment to their work.

We saw there were measures in place for assessing and monitoring the quality of the service provision. For example, the interim manager carried out regular audits and produced an action plan for matters requiring attention. Staff, people and relatives we spoke with said their views were regularly considered and they felt valued.

Policies and procedures were up to date, and regularly reviewed and understood by staff.