Northern Case Management Limited

Northern Case Management Leeds office

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?	**Good**

Summary of findings

Overall summary

We inspected Northern Case Management (NCM) Leeds office on 25 and 29 January 2016. This was an announced inspection. We gave the provider 48 hour notice of our visit to ensure that the registered manager of the service would be available.

The service is registered to provide personal care to people living in their own homes. The service provides care and support to people of any age who require rehabilitation following a brain or spinal cord injury.

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.

Systems in place to manage people's medicines were not robust. The service was not effectively ensuring staff had the correct information to administer the correct dose for people in the correct way.

The service did not use the Mental Capacity Act (MCA) 2005 during assessment and as part of care planning to evidence consent or best interest decisions being made on behalf of people.

There were systems in place to monitor and improve the quality of the service provided. Staff told us the service had an open, inclusive and positive culture.

Staff told us the registered manager and case manager team were supportive. Most staff had received regular and recent supervisions. Most staff had received an annual appraisal.

The majority of staff were up to date with training. Staff told us they had received training which had provided them with the knowledge and skills to provide care and support.

Assessments were undertaken to identify people's care and support needs. Care records reviewed contained information about the person's likes, dislikes and personal choices. There was evidence people and their families were involved in the process. The service was not always ensuring detail from risk assessments was transferred into people's care plans.

Effective recruitment and selection procedures were in place and we saw appropriate checks had been undertaken before staff began work. Gaps in employment and risks associated with starting a staff member before all necessary checks were in place were not always recorded.

Staff at the service worked with other healthcare professionals to support people. Staff worked and communicated with social workers, occupational therapists and hospital staff as part of the assessment and on-going reviews.

There were enough staff employed to provide support and ensure people's needs were met. People told us staff were reliable.

There were systems and processes in place to protect people from the risk of harm. Staff were aware of the different types of abuse and what poor practice would look like.

Prior to the commencement of the service, staff completed environmental risk assessments of the person's home. This meant the registered provider took steps to ensure the safety of people and staff.

There were risk assessments in place for people who used the service. The risk assessments had been reviewed and updated on a regular basis. Risk assessments covered areas such as mobility and eating and drinking. This meant staff had the written guidance they needed to help people remain safe.

People and family members told us staff treated them with dignity and respect. We observed staff were attentive, showed compassion, were patient and gave encouragement to people.

People were provided with their choice of food and drinks which helped to ensure their nutritional needs were met.

The registered provider had a system in place for responding to people's concerns and complaints. People told us they knew how to complain and felt confident the service would respond and take action to support them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems in place for the management and administration of medicines were not robust in ensuring safety for people.

There were sufficient staff employed to meet people's needs. The necessary checks required as part of the provider's recruitment process were not always recorded, but safe recruitment process was followed.

Staff were knowledgeable in recognising signs of potential abuse and said they would report any concerns regarding the safety of people to the management team.

Is the service effective?

Requires Improvement

The service was not always effective

The service was not using the Mental Capacity Act 2005 during assessment and as part of care planning to evidence consent or best interest decisions being made on behalf of people.

Most staff training was up to date and they valued the training they had received. Most staff had received supervision and where required an annual appraisal had been completed.

People were supported to maintain good health and had access to healthcare professionals and services. Staff encouraged and supported people to have meals of their choice.

Is the service caring?

Good

This service was caring.

People told us they were well cared for. People were treated in a kind and compassionate way.

People were treated with respect and their independence, privacy and dignity were promoted.

People were included in making decisions about their care. The

staff were knowledgeable about the support people required and about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place. Care plans contained person centred information about how people preferred to be cared for. Information from risk assessments was not always transferred to the care plan.

People we spoke with were aware of how to make a complaint or raise a concern. They were confident their concerns would be dealt with effectively and in a timely way.

Is the service well-led?

Good

The service was well led.

There were systems in place to monitor and improve the quality of the service provided, but the checks were not always recorded.

Staff were supported by their registered manager and case managers. Staff felt able to have open discussions with them through staff meetings and supervisions.

The service had an open, inclusive and positive culture.

Northern Case Management Leeds office

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

We inspected Northern Case Management (NCM) Leeds office on 25 and 29 January 2016. This was an announced inspection. We gave the registered provider 48 hours' notice we would be visiting.

The inspection team consisted of two adult social care inspectors. One inspector contacted people via telephone to discuss the service and the other inspector visited the registered provider's office in Leeds. .

Before the inspection we reviewed all the information we held about the service. The registered provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were seven people who used the service.

During the inspection we spoke with two people who used the service and four family members and/or other representatives. We also visited one person in their own home. We spoke with the registered manager, two case managers and five care staff. We looked at three people's care records, including care planning documentation and medication records. We also looked at staff files, including staff recruitment and training records, records relating to the management of the service and a variety of policies and procedures developed and implemented by the registered provider.

Requires Improvement

Is the service safe?

Our findings

We looked at the system in place for managing peoples medicines safely. We looked at the medication administration record (MAR) in use. The MAR did not contain sufficient detail to ensure staff had all the required information to support safe administration of medication. For example, there was no space to record the route the medicine should be administered.The medication policy dated December 2005 did not accurately reflect the complex management of medicines for people. For example, it did not describe how to safely write the MAR. It also did not describe what systems were in place to check staff were completing the MAR correctly.

The service did not have 'as and when required' (PRN) protocols in peoples care plans. PRN protocols are used to inform staff when it is necessary to administer medicines for particular symptoms 'as and when required'. There was no topical administration record to explain to staff where to administer creams and lotions on a person's body and for what symptoms.

As part of the inspection process we spoke with people who used the service who needed help from care staff to administer their medicines. People did not report any problems and they told us care staff were reliable and safe when administering their medicines.

The registered manager told us care staff had their competency in administering medicines assessed initially when they completed their training. The case managers and registered managers used information recorded on the MAR and medication errors reported to them to know if staff knew how to administer medicines safely. There was a system in place to observe staff administering medicines to people to ensure they were competent. However the document staff medicines competency was evidenced on did not demonstrate competence was checked against key tasks in the safe management of medicines administration.

We spoke with the registered manager about the system of managing medicines and they told us a review of the system would be completed.

The system in place to ensure people received their medicines safely was not robust.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we looked at the records of three newly recruited care staff to check the services recruitment procedure was effective and safe. The records we looked at showed Disclosure and Barring Service checks (DBS) had been carried out to confirm the staff member's suitability to work with vulnerable adults and children. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

We saw one staff member had started work prior to the DBS check being returned. The registered manager told us they had assessed the risk of this decision and balanced it against the urgent need to have support in place for a person. They had ensured a previous DBS check was seen and completed the initial stage of the DBS . This stage would be where a potential staff member's names were cross referenced against the barring lists of people who cannot work with vulnerable adults or children. The family of the person to be supported had also been involved in the decision. The service had not recorded this risk assessment to support their decision to authorise the staff member to start without a full DBS check.

References had been obtained and where possible this was taken from the last employer. We saw in one out of three staff files seen that gaps in potential staff's employment history were not explored to determine their suitability to work in the service. We spoke with the registered manager about safe recruitment and they told us they would improve documentation in the future.

Families and people who were supported by the service told us they were involved in the recruitment of staff for their package of support. One family member told us this was important to them as staff were spending time in their family home and they need to feel comfortable.

We were shown records which showed prior to the commencement of the service environmental risk assessments were undertaken of the person's home. We saw information to show individual safety checks had been carried out in each home setting for staff to be able to work safely. Visual checks were carried out on gas and electrical appliances to make sure they were safe for use. Other checks included checking the lighting and checking for clutter which could present a fire or falls risk. The registered manager told us equipment such as hoists would be checked to ensure they had been serviced and were fit for use. This meant the registered provider took steps to ensure the safety of people and staff.

There were risk assessments in place for people who used the service. Risk assessments covered areas such as eating, drinking and mobility. Care records also described how to keep people safe. For example a system of how to manage a person who displayed behaviours that may challenge was in place. Care records did not include how a person should be supported in the event of a fire in their own home to ensure safe evacuation. This meant staff would not know how to safely evacuate a person in the event of a fire.

All of the people we spoke with said they felt safe. One person said, "Yes they do keep me safe, they respect me and know my needs, we have built relationships." A family member told us, "My relative feels safe with them (staff)." Another family member told us how after a new staff member started working in the family home they were provided with a set of keys once they trusted the staff member, usually following their probationary period. They had agreed to this system.

We asked staff about their understanding of protecting people who used the service from harm. Staff were aware of the different types of abuse and what to do if they witnessed any poor practice. The registered manager was aware of local safeguarding protocols. Staff told us they had received training in in the safeguarding of vulnerable adults. They told us the training had provided them with the information they needed to understand the safeguarding processes that were relevant to them. The records we looked at confirmed staff had received training in this area.

People who used the service and family members we spoke with during the inspection were aware of who to speak with should they need to raise a safeguarding concern. We found the service had safeguarding and whistle blowing policies and procedures in place. These outlined to staff what action they needed to take if they suspected a person was at risk of abuse.

We saw the log of concerns the registered manager used to keep track of safeguarding incidents. The registered manager had taken immediate action when incidents occurred in order to protect people and minimise the risk of further incidents.

The registered manager told us the service provided 24 hour support for people. This meant some staff visited people at their home when the office had closed. The registered manager told us how senior staff were available out of hours to provide support to staff. This showed the registered provider took steps to ensure the safety of people who used the service and staff.

We looked at the rotas for people who used the service. We could see each person had their own rota with staff and finish times of shifts based on their personal preference, routine and needs. Each day was flexible for people to change times and shifts if they needed to. For example, one person had different shifts when on school holidays or when going out for the day on activities. This meant the rota system was very person centred. The case manager or team leader completed the rota for each individual package of support. Each package of support had its own staff team allocated and people all confirmed they had a consistent team of people supporting them. We saw the service worked closely with people to ensure the rota met their needs. We found one family member received their rota via email to ensure they had an up to date version.

Requires Improvement

Is the service effective?

Our findings

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. We found the registered provider had a group of policies and procedures which outlined the MCA process. However we could not find any evidence they were being followed robustly.

The registered manager told us they assume people who used the service had capacity unless they were told otherwise. The registered manager told us if they had any concerns in relation to a person they would inform the person's social worker or health care professional. We were told where necessary other professionals involved in their care would undertake assessments in relation to mental capacity. However we saw people who did not have capacity did not have relevant MCA or best interest decisions documented in their care records. For example, one person was supported to take medications and they did not have the capacity to understand what they were for. Another person was restrained whilst travelling in a vehicle with a harness and potentially did not understand the process and what it was being used for. We spoke with the registered manager about MCA and evidencing consent. They told us they would be looking into how they can include MCA into assessment and the care planning process.

Staff we spoke with understood their obligations with respect to people's choices. Staff told us people and their families were involved in discussions about their care. The training matrix we were given did not include Mental Capacity Act (MCA) 2005 training for staff. Staff we spoke with told us they knew very little about the MCA. One staff member told us they had not heard of the MCA. The registered provider told us that MCA is discussed as part of other training courses for example, safeguarding and medication. However staff knowledge of MCA did not reflect that this approach was effective in ensuring staff understood MCA. The service was not using the MCA during their assessment and care planning process to evidence consent or decisions made in people's best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with during the inspection told us they felt well supported and they had received regular supervision from their line manager. Staff told us supervision was valuable. We saw records evidencing staff had received supervision and those who had been in employment for more than 12 months had received an appraisal. However, bank workers who carried out occasional work when required had not had any supervision. This meant they had not been supported by the management team of received feedback on their performance.

The registered provider showed us a competency tool they had recently introduced which was used to assess and monitor the competence of the case managers. The document outlined a set of standards each case manager must meet to demonstrate competence in their role. This new innovation was being rolled

out from the end of 2015 for the whole of 2016. This process ensures that each case manager is working to a high standard in their work supporting people who use the service.

The registered manager showed us information which detailed training staff had undertaken. The training matrix showed training was mostly up to date for staff and also identified where staff had been booked on to training they needed to complete.

We saw staff had also completed specialist training to help them understand how to support people with more complex or specialist needs. Topics included challenging behaviour, epilepsy, background in brain injury and rehabilitation.

Staff confirmed the quality of the training was good and provided them with the skills and knowledge to do their job. One staff member told us, "Training is good. They let us know when refresher training is due and the person I support also attends some training they want to."

People we spoke with thought the staff providing the care were well trained. People we spoke with told us they thought the staff members understood what their care needs were.

The service provided support to people at meal times. Those people who were able were encouraged to be independent in meal preparation. Staff encouraged and supported people to have meals of their choice. One person said, "Staff help and they are good cooks." Another person said, "I go shopping with staff and select what I want. We work together to buy healthier options. Some cooks are better than others but I am satisfied." The registered manager and staff told us they supported people to monitor their weight and diet where issues had been highlighted. We saw evidence of this in people's care plans.

The registered manager and staff we spoke with during the inspection told us they worked with other healthcare professionals to support people. The registered manager told us how they communicated with social workers, occupational therapists and hospital staff as part of the assessment process and on-going care. For example we saw a person with epilepsy had very clear protocols to help manage a situation if they had a seizure.

Good

Is the service caring?

Our findings

All of the people and their family members we spoke with were very complimentary about their staff and their caring attitude. Comments included; "[staff member name] is really good, they make a difference they liaise with people and keep me informed, they listen to people." Another person said, "My carers know me well." A family member told us, "It is hard living with carers, but we need them and I can't fault them. No one is perfect but we have a good team."

The registered manager told us there was a person centred approach to the support and care people received and this was evident in the way the staff spoke about people who used the service. Staff spoke with kindness and compassion and were highly committed and positive about the people they supported. Staff knew and understood the individual needs of each person, what their likes and dislikes were and how best to communicate with them so they could be empowered to make choices and decisions. One person told us, "I am vocal and talkative. I am involved and I take ownership of my care."

We saw the registered provider's key policies and procedures contained information on the service's values and beliefs such as; privacy; dignity and respect; equality; independence; rights; and confidentiality. The registered manager told us these values and beliefs were communicated during inductionand training that staff received. It was clear from our discussions with staff that these values underpinned the work they carried out with people.

People's diversity, values and human rights were respected. Staff demonstrated to us they knew how to protect people's privacy and dignity whilst assisting with personal care for example, ensuring they gained consent before entering peoples bedrooms and homes. One person who used the service told us how staff maintained their dignity and privacy, they said, "They close my curtains and windows to help protect my privacy and dignity." A staff member told us, "When people have visitors we always leave them in private."

People we spoke with during the inspection process told us how staff were supportive. Some people we spoke with thought staff promoted their independence because they encouraged them to do as much for themselves as possible. One staff member told us, "I make sure people take part in whatever they can for example, washing the dishes, doing the laundry, it makes people be independent."

During our visit to the home of a person who used the service we saw how the two staff engaged in friendly banter with the person. We saw the staff engaged the whole family and friends in the person's life; we were told team work from everyone ensures they do the best for the person. For example, how everyone was working to empower one person to use technology to aid communication and reduce frustration for the person.

Care files contained information about people's life history. This gave important information about people's background and their likes and dislikes. This information helped staff to provide more personalised care.

Good

Is the service responsive?

Our findings

People we spoke with told us they were happy with the care they or their family member received. One family member said, "They are professional and aware of [name of person's] needs." Another family member told us, "Staff are respectful of my role as mum and this makes me feel in control and that my opinions are listened to."

During our inspection we reviewed the care records of three people who used the service. Each person had an assessment which highlighted their needs. Following assessment, care plans had been developed. The care plan section of the records described in a person centred way how people liked to be supported. For example how to plan for activities and support the person to participate and understand when it was time to end the activity to prevent anxieties. Another person's care plan detailed how staff must ensure the person felt comfortable with their appearance by watching body language and facial expressions.

Peoples' care records had been reviewed regularly and were up to date. We saw at times information in the assessment or risk assessment was not always transferred onto the care plan. We spoke with the registered manager who told us they would work with the case managers to address this issue. People and families confirmed they had been part of developing their care plans and they were involved in their review.

We saw the care plans were up to date in the person's home and they matched the copy held in the office. This meant everyone involved had access to accurate information about the care support people needed. We saw people had good opportunities to develop interests and access activities they liked with staff support. For example, one staff member told us they had supported a person to access indoor skiing. This had involved supporting the person to develop budgeting skills to enable them to afford the activity. Another person's file showed they had regularly gone to the football so they could support their favourite team at home and away games. Staff told us how the person had friends at the football. One family member told us how they were pleased staff were thinking for their relative by picking new activities with them. The family member told us about a recent visit to Blackpool and we saw photos of everyone enjoying themselves. The person themselves confirmed this to us.
During our visit to one person's home, we observed staff empowering the person through good communication in their own preferred way. The most effective communication methods were described in the person care plan.

Everyone we spoke with knew how to contact the office and the case manager who was linked to their care package. People said when they contacted the office staff were polite and helpful. We saw file notes which documented the feedback or contact with each person and their family. Staff involved families by asking them for suggestions which could be addressed as specific agenda items at staff team meetings.

The registered manager showed us the complaints received in the past 12 months. We saw the registered manager ensured all complaints were tracked and dealt with appropriately. We looked at the complaints procedure which informed people how to make a complaint. The procedure specified timescales the provider should work within to take action.

We were told case managers maintained regular contact with people and family members to make sure they were happy with their care and support. Most people we spoke with told us they had never had to make a complaint and those who had complained told us their concerns had been dealt with quickly and to their satisfaction.

Good

Is the service well-led?

Our findings

At the time of the inspection there was a registered manager in post. The registered manager managed two sites for the registered provider. The people who were supported had a case manager identified to oversee their care and support package and this was the staff member people and their families saw as their link to the organisation.

People who used the service, family members and staff we spoke with during the inspection spoke highly of the service and their case manager. They told us they thought the service was well led. One staff member said, "It is a good organisation to work for, best thing is their commitment to their staff." All of the people we spoke with said they would recommend the service to other people.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their service. We were told by the registered manager and the case managers that they frequently monitor areas such as care plans, incidents and complaints in the service. Case managers also told us that they regularly visit staff when they are providing support to people in their homes and they observe that staff practice is safe and positive. Case managers also told us they seek feedback from people supported and their families plus a range of professionals involved in the package of support for people.

We saw that the case managers recorded their visits to people's homes and feedback received within a file note on a computer system. For example we saw recorded feedback from one person's family member about information they wanted to be passed to staff and this had been communicated to staff in a subsequent team meeting. The case managers could tell us the details of each package and the current issues they were dealing with. However there was no standard to measure quality against or schedule of the frequency of audit.

The registered manager was responsible for monitoring the service on behalf of the registered provider. We were shown copies of management meeting minutes where items were discussed which influenced change because a pattern of poor quality had been noted, new legislation had been introduced or good practice was discussed. These management meetings were held at the registered provider's head office in Bury and the case managers from Leeds were not frequently attending, but the registered manager told us they were being supported through technology to join the meetings in future. The Leeds case managers confirmed they received copies of the minutes.

The registered manager spent time in the Leeds office each week and case managers told us they were a great support and available at any time for advice. Systems were in place for the registered manager to see if care plan reviews, risk assessments and staff training were up to date. We were told by the registered provider following the inspection the registered manager recorded these checks in case manager's supervision records alongside any action plans where issues may have been found. We saw from some records for example the care plan review tracker that care plan reviews were up to date.

We spoke with the registered manager who told us there were clear lines of management and accountability and all staff who worked for the service were very clear on their role and responsibilities. Staff told us the registered manager and case managers had an open door policy so staff had access to support at all times. From discussion with staff we found the case managers were effective role models for staff and this resulted in strong teamwork, with a clear focus on working together.
Staff told us they were aware of the whistleblowing procedures and would have no hesitation in reporting concerns about the quality of the provision.

We asked the registered manager about the arrangements for obtaining feedback from people who used the service. They told us surveys were sent out to people on an annual basis to seek their views on the care and service provided. We saw results of the annual survey from 2014/15. The results were positive and NCM highlighted actions they would take to improve where they needed to following feedback. For example 77% of people who returned the survey felt they had enough say in their care and treatment. NCM agreed to focus on this feedback with case managers by promoting this at team meetings. We saw evidence this was happening.

Staff told us they were kept up to date with matters that affected them. We saw records which confirmed staff meetings took place regularly in peoples own homes with their family and staff team where appropriate so that everyone were part of reviewing and developing the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people were unable to consent because they lacked capacity the service was not using the Mental capacity Act 2005 to assess and record decisions in people's best interest. (1), (3) Need for consent.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service was not ensuring proper and safe management of medicines. (1), (2) (g) Safe Care and Treatment.