Kirklees Metropolitan Council

South Short Term & Urgent Support

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 28 June 2016 and was announced. The service had previously been inspected in 2014 and had met all the regulations in place at that time.

South Short Term & Urgent Support provides a reablement and a rapid response service. The reablement service provides support for up to six weeks to help people to live independently. The rapid response service supports people for up to five days to prevent admission to hospital or in the event of a break down in carer arrangements. The team is made up of both health and social care professionals. South Short Term and Urgent Support is regulated by the Care Quality Commission to support people with the activity of personal care.

There was a registered manager who had worked at the local authority for 30 years and registered with the Care Quality Commission since 2010. 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.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Risks were managed at the service and there were systems and processes in place to ensure environmental risks were minimised. The registered manager was fully aware that to promote people's independence meant using a positive risk approach to manage risk. By not being overtly risk averse they supported people to acquire new skills or regain lost skills.

Staff completed the Care Certificate on taking up their post or where gaps in knowledge had been highlighted. They were allowed time to develop into their role by shadowing more experienced staff. Staff received regular training to ensure they developed skills and knowledge to perform in their role and regular supervision and appraisals to support their development and they told us they felt supported in their role.

Staff had received training in the Mental Capacity Act 2005 and the team had a Community Assessment & Support Officer (CASO) attached to the service to work with people who might lack capacity. We found some staff could not confidently define the principles of the Act but were able to describe how they would support people who lacked capacity. The service usually worked with people who had capacity to be able to consent to a reablement programme.

Staff were passionate about reablement and maximising people's independence to live fulfilled lives. People using the service spoke highly of the staff at the service and their attitude and approach in encouraging independence.

People received care that met their needs, choices and preferences. The time allocated to meet people's needs at each visit was flexible to ensure the best outcomes for people using the service and we found evidence which detailed people had been involved in the compilation of their support plans to enable agreed goal plans to be determined.

A clear management structure and shared values, along with an open and transparent culture meant staff understood their roles and responsibilities.

Processes were in place for reflecting upon and evaluating the quality of care provision and these were being developed further as the service evolved and changed. The registered manager and the team were involved at a strategic level developing the service, involving staff appropriately in setting the direction which tied in with the goals of the organisation and national direction for integrating health and social care services.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

Risks were managed at the service and there were systems and processes in place. The service balanced the necessary levels of protection without being overly risk averse in order to give people confidence to develop their levels of independence.

Staffing levels were tailored to meet the needs of the individual and were not restricted or inflexible.

Is the service effective?

Good

The service was effective

People were cared for by staff who were well trained and supported to meet people's needs.

Staff received supervision, appraisal and feedback to ensure they developed in their roles and were motivated to develop.

Staff supported people to maintain healthy lifestyles if this was identified in their support package.

Is the service caring?

Good

The service was caring.

People told us staff were caring and compassionate in their approach.

There was a clear emphasis on promoting people's independence and staff had engaged people in achieving their goals.

Staff respected people's dignity and were respectful of people's wishes and preferences.

Is the service responsive?

Good

The service was responsive.

People received care that met their needs, choices and preferences and the service was flexible to ensure the best outcomes for people using the service.

Care plans detailed the support people required and evidenced people had been involved in the support planning process.

Staff were focused on person-centred care and involved people with every stage of their progress, in ways that encouraged and enabled people.

Is the service well-led?

Good

The service was well-led.

Staff told us the registered manager was supportive and the team was well-led. The registered manager had successfully embedded the change at the service to an ethos of reablement from a traditional home care model of care.

The culture of the organisation was good. All staff had great pride in their work and in the organisation and were passionate about the service they provided.

The service was continually striving to improve and was aware of what they did well and what they could do better.

South Short Term & Urgent Support

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 provider was given 48 hours' notice because the location provides a domiciliary care service.
The inspection was carried out by one adult social care inspector.

Prior to the inspection we reviewed all the information we had about the service including statutory notifications. The registered provider had been 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. We contacted the local authority and Healthwatch to see if they had any feedback about the services provided.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke by telephone with four people who used the service and one relative of a person. We also spoke with the registered manager, the manager supporting the registered manager and three support assistants. We also spoke with two professionals on the day of our inspection to obtain their perspective on the service provided.

We looked at three people's care records plus seven people's risk assessments. We also looked at three staff recruitment files and records relating to the management of the service including policies and procedures.

Good

Is the service safe?

Our findings

People we spoke with all told us they felt safe with the service provided to them. They told us how the staff supported them to manage risks to be able to regain skills they had lost such as getting dressed and using the microwave. One person said "I feel safe with the care. They are excellent."
We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. Staff knew the whistleblowing procedure and said they would be confident to report any concerns with poor practices if they witnessed this in order to ensure people's rights were protected.

We asked the service how they managed risk to keep people safe. The registered manager told us once the service received a referral an assessment was undertaken which included the completion of a risk identification form. If any risks are highlighted a further risk assessment was undertaken specifically to ensure the risk was managed. We found risk assessments were individual to people's needs and minimised risk whilst promoting people's independence. There were comprehensive risk assessments in place for areas such as falls, environmental risks, infection control, fire and moving and handling. As the service included therapists as part of a person's reablement programme, we were shown risk assessments which incorporated both actions to reduce risk by the therapist and actions to reduce risk taken by the provider such as around a person's ability to climb the stairs. This meant there were clear lines of responsibility in terms of managing the same risk from different professional perspectives to ensure the safety of the person supported and the member of staff supporting them.

Risk assessments were detailed and included measures to mitigate risks to people. For example, one person had a falls risk assessment in place which looked at factors which may increase a person's risk of falls and followed national good practice guidelines. Their assessment included an analysis of the person's medication, mobility, environmental hazards, psychological factors, continence, nutrition, footwear, and visual and hearing impairments. If factors contributing to falls had been highlighted, measures were implemented to improve safety in those areas. The examples we reviewed demonstrated the service was meeting the regulations in terms of assessment and mitigation of risks to people who used the service.

The service employed a total of 121 staff but recruitment was ongoing to ensure the service had the correct amount of staff. The registered manager told us they had implemented an innovative rolling 12 month recruitment process and they held events every three months to try to recruit into this service and to encourage people into the caring profession. They advertised widely through social media and involved existing staff at all levels to meet and greet people who might be interested in a career in this sector. The local authority recruitment team attended the events to do the necessary pre-employment checks. This had cut the recruitment process timeframe significantly .This meant the service was successfully recruiting candidates to meet the needs of the service whilst ensuring new staff had the skills and behaviours required to provide a high standard of care to the people using this service.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the service. This included a Disclosure and Barring Services (DBS) checks, reviews of

people's employment history and two references had been received for each person.

As part of our inspection process we checked to see whether people's medicines were managed appropriately. The registered manager told us the person or family members usually ordered medicines for people using the service but the staff would contact the pharmacy service if people did not have their medicines. They would assist with the administering or prompting medicines if this had been identified as part of the person's assessed need. The registered manager told us significant work was ongoing with managing medicines in people's homes and they were working with the local authority commissioning team to pilot documentation to be used by the independent sector in the area. This documentation would provide clear support plans to enable staff to support people using services to manage medicines safely and effectively. Staff at the service worked with the primary care teams who provided training and support to manage a person's health needs, such as the administration of eye drops and with catheter care. The registered manager told us the primary care team assessed staff as competent to administer medicines and observed staff practices in this area.

We asked the registered manager how accidents and incidents were reported. They told us staff reported any incidents to the office or out of hours service. If a person had fallen we were told as a follow up the service would either involve the therapist in the team or make a referral into the falls prevention team. This demonstrated the service responded to incidents and used this information to improve safe practice.

The service had recently worked in partnership with the infection control team to develop good practice around infection prevention and control. We were shown a workbook and guidance for community health and social care staff which provided staff with all the information required to reduce and manage the risk of infection. The registered manager told us staff were provided with personal protective equipment which enabled them to carry out their caring duties safely. We observed supplies were kept in the office for use in people's homes. This confirmed staff had access to appropriate protective equipment to enable them to safely carry out their duties.

Community equipment such as hoists and slings were provided and serviced through local community equipment service arrangements. The management team told us they received Medicines & Healthcare products Regulatory Agency (MHRA) notices through the moving and handling team or through the community equipment service. Once information was received it was cascaded to front line staff to ensure any equipment issues were acted upon. Any requirements on safe equipment usage would be inputted onto the person's support plan for all staff to read. They told us of a recent issue in relation to the safe use of air flow mattresses where they had checked everybody using this equipment and undertook a risk assessment on the safe use of the mattress. We also found evidence in a team meeting that health and safety was a key item for discussion. For example, at a team meeting which took place on 13 April 2016 an alert relating to bed rails was cascaded with a reminder to staff that people with bed rails required a risk assessment to determine the safe use of this equipment. Staff were alerted to inform the office or out of hours if they found a person using the service in the community who had been provided with bed rails in the past, to ensure a risk assessment was completed. This demonstrated the service was acting on alerts to ensure the safety of people using the service.

Good

Is the service effective?

Our findings

People we spoke with all told us staff had the knowledge and skills to care for them. One person said, "All the one's I've had have been well trained." The registered manager told us all new staff undertook the Care Certificate to induct them into their caring role. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. The registered manager told us existing staff completed the Care Certificate self-audit tool and if gaps were identified additional support was provided and they were encouraged to complete the relevant section of the Care Certificate. The registered manager told us they had set up weekly drop in sessions for staff to be supported in progressing and completing the Care Certificate, which they described as being "The most comprehensive induction training."

The staff we spoke with told us they supported new staff into the service as new staff shadowed experienced staff to gain confidence. They told us existing staff worked with new staff until they felt confident with the role and they were given the opportunity to feedback about the new member of staff's performance. Staff told us they were well trained and supported to carry out their role. They told us they had access to the local authority online training and development service with access to their own training and development area. One support worker said, "Training is ongoing all the time."

We saw evidence in the electronic training matrix that staff regularly undertook training to enhance their role and to maintain their knowledge and skills relevant to the people they supported. Training was a mixture of computer based and face to face learning and included topics such as safeguarding adults from abuse, infection control, data protection and moving and handling. We found staff development to be high on the agenda at the service, with the management team working with different partners such as infection control and commissioning to develop guidance for staff in these key areas. Information was cascaded to staff through meetings and one to one sessions, to ensure staff had up to date information and guidance on best practice.

Regular supervision of staff is essential to ensure that people at the service are provided with the highest standard of care. The registered manager told us staff received supervision every three months and this would be a combination of community supervision where staff were observed practising in people's home's, group supervision sessions, 1:1 supervision or an annual performance appraisal. All the staff we spoke with told us they had regular supervision.

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 registered manager told us all staff had received training in the Mental Capacity Act 2015 and had access to information to support them. Most of the people the service supported had capacity to consent to reablement and required a level of capacity to be able to engage with the goal setting required for a successful programme. They told us although questions around capacity formed part of their initial assessment process they were aware it was an area the service needed to develop. Staff we spoke with could not confidently describe the principles of the MCA but when staff described how they worked with people who might lack capacity we found they were working within the principles of the legislation. The registered manager told us a Community Assessment and Support Officer (CASO) was attached to the team and where it had been identified a person might be lacking capacity the CASO became involved to undertake decision specific capacity assessments and support best interest decision making to ensure the service was working in line with legislation.

We saw evidence in the care files we looked at that consent was sought from people using the service. In addition, people's continuing consent was sought by the care worker at each intervention. This was confirmed by the people we spoke with following our inspection.

We found the service was working with other health and social care colleagues to ensure the best outcomes for people. This included assistive technology, social care colleagues, equipment services, and health colleagues. At a strategic level the service was being redesigned to be part of a fully integrated health and social care hub to deliver better outcomes to the people using the service. The service supported people on a reablement package of care with meal preparation and encouraged healthy eating lifestyles. The registered manager told us they worked closely with other professionals to build this into support plans and had supported people requiring a diabetic diet and gluten free diets. Staff had the opportunity the previous year to attend a healthy eating course so they could gain the skills and knowledge to encourage the people supported to maintain healthy eating regime. This demonstrated the service was working to ensure the best outcome for people supported.

Good

Is the service caring?

Our findings

All the people we spoke with commented on the caring nature of the staff and the quality of their interaction with them. One person said the staff were, "Very caring, very pleasant and very open." Another person said, "They are very kind, very considerate. Really lovely. Couldn't be better." The registered manager told us ensuring staff were caring was one of the key attributes they looked for in the recruitment process. They told us "it is a crucial criterion". They asked focussed questions at interview geared towards the principles underlying care to ensure this aspect of candidate's behaviour was drawn out during the recruitment process. Once employed, staff were continually assessed for this behaviour through supervision, including during community supervisions where they were observed with the people they supported.

We found staff spoke in an enthusiastic and passionate way about their role in the reablement service. There was a shared goal of promoting people's independence and guiding them towards their agreed outcomes in an empowering way. One member of staff said "I love it. I love being able to plan with the service user from coming out of hospital to getting them to the level of independence. That's what I enjoy." Another member of staff told us "There is a quick turnover of people using the service as reablement is up to six weeks. It works. It's good." This member of staff explained how rewarding they found supporting people to be independent and said they used a mix of skills such as 'patience, praise, firmness, different methods of communication' to encourage the person to achieve their desired outcomes.

The ethos of the service was to support and encourage people to be as independent as possible and to give choice and control over the service people received. The registered manager told us "The nature of the service is to take positive risks, not being risk adverse in helping people achieve their goals. Staff are resourceful, encouraging people and building confidence to be independent." They told us staff were supported by therapists to encourage independence and to learn how to set goals. We found evidence in people's care plans their views and opinions had been sought as to their current level of independence and the level they aspired to achieve. One relative told us they were helping their relation to "Learn how to fasten shirt buttons and put their socks on." They spoke highly of this as although it took a long time, they were getting satisfaction from doing it themselves.

We were also told there were no time restrictions on staff supporting people with reablement to ensure staff had enough time to encourage people to undertake tasks themselves which often took longer than staff doing the activity for the person. The service was also flexible to accommodate for people's changing needs with the ability to increase or decrease service accordingly. Once the period of reablement ended the service supported people to transition to an independent provider if it had been determined they had ongoing support needs.

People told us staff always respected their privacy and dignity. Staff told us they always respected people's privacy and dignity such as ensuring people were covered by a towel during personal care, keeping the door shut and the curtains closed. One member of staff said "You wouldn't like it if you were on show. Treat people how you want to be treated. Ask the family to leave the room whilst you are supporting the person."

People using the service told us staff always treated them with dignity and respect. One person told us staff were "Respectful and polite." Staff also told us how they ensured information about the person remained confidential such as making phone calls about a person in the privacy of their car where people could not overhear. This demonstrated staff understood this important aspect of their role.

The service provided people using the service with information at the start of the process including what to do if they were unhappy with the service provided. The service sought feedback from people using the service including the question "do you feel treated with dignity and respect." We saw evidence which supported the view that people's privacy and dignity was respected. The registered manager told us they received a high number of compliments which were passed to the Head of Council and the Head of Service who in turn thanked members of staff directly. This demonstrated staff were rewarded when showing positive behaviours which aligned with the values of the organisation.

Good

Is the service responsive?

Our findings

People we spoke with confirmed they had been involved in setting their goals. One person said, "I wanted to be able to get myself washed and dressed. I could manage in hospital but when I came home I found I couldn't manage it. I can do it now." People received care that met their needs, choices and preferences. The registered manager told us the time allocated to meet people's needs at each visit was flexible and adjustments were made following feedback and assessment from staff about people's improving abilities.

The registered manager told us following receipt of a referral a locality manager would go out to undertake a person-centred support plan which involved working with the person to set goals and outcomes and this initial support plan remained in the person's home. We saw evidence in people's files which confirmed the service worked with people to achieve the aims agreed with them and recorded in their support plans. Support plans consisted of different areas of activities of daily living such as personal care which recorded information against the following domains: "My identified support needs are" "What I am able to do myself" "The outcomes I want for each of my support needs are" and "I would like my support needs to be met in the following way, including number of visits and staff."

In one of the care records we looked at the person had an identified support need around the management of personal care. The assessor had worked with the person to identify what they could do themselves and what they required assistance with. The recording was person centred and put the individual at the centre of their support plans. There was clear evidence to show the service had taken the views of the person into account when devising their support plans and what mattered to the person which included the time when people wanted to receive reablement support. We evidenced the following recording in one person's care records "[Person's name] has requested late morning and evening call where possible to accommodate normal routine. The flexibility to accommodate this preference in itself encouraged the person to regain their normal daily routine.

Staff told us they fed back any change in people's needs to the office or the care coordinator. The care staff we spoke with told us they were not involved in the reviews for the people they supported but they did provide information to inform the reviews. Staff said there were regular patch meetings once a week where they discussed peoples' progress, how they were doing and what had changed. One support worker told us these meetings were, "A good way of communicating changes."

People using the service were given a reablement questionnaire before the service started which included questions about their quality of life, health, mobility, anxiety, self-care, control over their daily lives and social contact. They were asked the same questions post reablement which enabled the service to monitor the effectiveness reablement was having in these key areas. The aim of the service was to support people to achieve their potential in a set time frame and once this potential had been reached, to either exit services or move people onto the independent domiciliary care agency sector.

Staff told us they always offered choice when supporting people, from what they wanted to wear to what they wanted to eat. Depending on the needs of the person and level of support they required, staff told us

they would support people with a hot meal, a sandwich or leave them snack to eat depending on their choice that day.

We asked staff what they would do if a person made a complaint to them. They told us they would deal with it if they could but take the information back to the coordinator or office. The local authority had a formal policy for dealing with complaints and the registered manager told us learning was always put in place after a formal complaint and a complaints resolution plan.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post who had been working for the local authority for 30 years. They were supported in their role by a second manager who was not registered with the Care Quality Commission. We found they worked closely in partnership with other professionals to ensure people's care needs were met. We spoke with a professional working closely with the service who told us how the health and social care services had worked together to develop services which had benefited people using the services. They had looked at ways of sharing paperwork, documentation and endeavouring to resolve issues relating to different technology systems. They told us the service achieved 'good outcomes.' and said "Partnership working is excellent. It's because we have a mutual understanding of each other's role. Both organisations want to do the best for the community from both social and health models. Both want the best outcome." This demonstrated the service worked in partnership with other services to improve the experiences of people using both community health and social care services.

Leadership was evident and staff told us the service was well led and the management were understanding and approachable. One person said "[Name of registered manager] is the best manager I've ever had." The registered manager told us they involved front line staff in the development of the service. A meeting was held with senior managers every three months and a staff representative from each locality was encouraged to attend. Staff were also involved in various working groups to input into the development of services and improving practice such as a working group looking at all elements of training. The service had leads in specific areas such as infection control. The management team told us the culture was open and honest. They encouraged staff to come to speak with them to discuss any issues they might have. The registered manager told us that in their view staff did not have any qualms about coming to the management team and they were honest and vocal about their views of proposed changes which was confirmed by the staff we spoke with.

Staff told us how much they enjoyed working at the service. Comments included "We are a good team. We work well together. We cover each other; we report back to each other and swap shifts if needed to help each other out."

The registered manager shared the vision for the service with us "To have a community care team model of integrated working. " Work had commenced strategically on the development of this new model and a pilot was due to commence in one hub to develop the Early Intervention and Prevention New Council model of care. The registered manager said "We are passionate about it. Through integration and working together that's how you achieve things. We are here for the service users. It's about who is the most appropriate person to be involved. We have the commitment and passion across the health and social care sector."

Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service. The registered manager told us the service had regular meetings. These included weekly meetings with support staff in the six localities, a four to six weekly locality manager and coordinator meeting and separate meetings with the therapy staff and Community Assessment & Support Officer (CASO). We saw the minutes

of the latest meetings which demonstrated the service communicated effectively with the different staff groups to enable them to monitor the service and obtain feedback.

The registered provider assessed and monitored the quality of the service provided to people through reports from the service. Quality information was reported to senior management. They told us they kept up to date with good practice in the field by utilising the Care Quality Commission website, weekly information provided by the local authority newsletter 'In the know', through strong links with the local authority commissioning team and following national good practice guidance.

Regular audits were undertaken at the service such as supervision audits, health and safety audits and appraisal audits. The service had a dashboard system to enable report information to be compiled electronically and a monthly performance meeting was held to feedback information to senior management.

At the current time the registered manager told us they were working on a system to deliver consistent quality monitoring at the service. They did not have a framework to report care plan audits into but they were aware of this and they would have a system in place in the future. The service completed an annual team plan which all staff were encouraged to contribute towards. This looked at what had gone well over the previous 12 months and what had not gone well. The plan included the team's areas for development over the coming 12 months. The registered manager told us the team plan was a working document shared with locality managers and coordinators and with staff at team meetings. This showed us the team was involved in ongoing and continuous efforts to improve their performance.

The service sought the views of people using the service and had received 256 questionnaires between January and April 2016 and we were shown a sample of feedback received. The service was constantly reviewing its performance. A 'deep dive' had been undertaken recently which involved a detailed case track of a person's journey through the services. This highlighted learning points and triggers and identified areas where services could improve by identifying people who required a case management approach with more intense support early on. The registered manager told us of other developments to improve practice between health and social care services, such as a shared communication sheet. This enabled health and social care staff at a glance to see any changes to a person's needs or significant information. Once finalised this will be shared with the independent domiciliary care sector to develop good practice for all community services.

There had been some confusion at the service about when to notify the Care Quality Commission in relation to some statutory notifications. Clarification was provided following the inspection and the registered manager confirmed future practice would be in line with the updated guidance.