MacIntyre Care

MacIntyre Central England Support

Inspection report

Enterprise House
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Bicester
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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

We undertook an announced inspection of MacIntyre Central England Support on 21 April 2016.

MacIntyre is a charity dedicated to providing a range of teaching and learning, support and care services to people with learning disabilities through domicillary care and supported living. At the time of our inspection eight people were receiving a personal care service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were greeted warmly by staff at the service who seemed genuinely pleased to see us. The registered manager checked our identity before allowing us to proceed with the inspection. The atmosphere was open and friendly.

Relatives told us people were safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff who were knowledgeable about people's needs and provided support with compassion and kindness. People received high quality care that was personalised and met their needs.

Where risks to people had been identified risk assessments were in place and action had been taken to reduce the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicine as prescribed.

There were sufficient staff to meet people's needs. Staffing levels and visit schedules were consistently maintained. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Most staff understood the Mental Capacity Act (MCA) and all staff applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected, this included Deprivation of Liberty Safeguards (DoLs).

Relatives told us they were confident they would be listened to and action would be taken if they raised a concern. The service sought people's and relatives opinions through regular surveys and telephone contact. The service had systems to assess the quality of the service provided. Learning needs were identified and

action taken to make improvements which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

Staff spoke positively about the support they received from the registered manager. Staff supervision and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service.

Relatives told us the service was friendly, responsive and well managed. Relatives knew the managers and staff and spoke positively about them. The service sought people's views and opinions and acted upon 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?

Good

The service was safe. There were sufficient staff deployed to meet people's needs.

People's relatives told us people were safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place to reduce the risk and keep people safe. People received their medicine as prescribed.

Is the service effective?

Good

The service was effective. People were supported by staff who had the training and knowledge to support them effectively.

Staff received support and supervision and had access to further training and development.

Staff had been trained in the Mental Capacity Act (MCA) and applied its principles.

Is the service caring?

Good

The service was caring. Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive. Care plans were personalised and gave clear guidance for staff on how to support people.

People's relatives knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make

sure their needs could be met.

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service.

The service shared learning and looked for continuous improvement.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

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

This inspection took place on the 21 April 2016. It was an announced inspection. We told the provider two days before our visit that we would be coming. We did this because the registered manager is sometimes out of the office supporting staff or visiting people who use the service. We needed to be sure that someone would be in. This inspection was carried out by three inspectors.

We spoke with three people's relatives, four care staff and the registered manager. We looked at four people's care records, staff files and medicine administration records. We also looked at a range of records relating to the management of the service. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care.

We looked at previous inspection reports and reviewed the notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

In addition we contacted the local authority commissioner of services to obtain their views on the service.

Good

Is the service safe?

Our findings

People's relatives told us people were safe. Comments included; "Yes he is definitely safe", "Always enough staff and he has regular staff who know him well", "She is kept safe by staff when they are supporting her" and "He always has two staff with him when he goes out". The service conducted 'safeguarding' assessments to assess the person's vulnerability to the risk of abuse. These assessments linked to support plans. For example, one person could present behaviours that may challenge and this was identified as a potential safeguarding risk. The assessment linked to the 'behavioural support plan' and gave staff guidance on how to safely protect the person.

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to their manager or senior person on duty. Staff were also aware they could report externally if needed. Staff comments included; "I would inform outside agencies such as the Care Quality Commission (CQC) and the local authority safeguarding team", "I can complain to my superior if I'm not happy about anything" and "We have a whistleblowing policy. I have never had to use it but I know how to. I can whistle blow to CQC". The service had systems in place to report any safeguarding concerns to the appropriate authority.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person could not be left alone in the bath due to their condition. Detailed guidance was provided for staff on how to safely support this person. This included 'staying with the person at all times' in case they had a seizure.

Another person was at risk of falling when they became tired and needed assistance with their mobility. The person could become tired when walking independently for long periods of time. Staff were guided to support the person by ensuring their wheelchair was available for them if they became tired. Other risks managed included choking, behaviours that may challenge and general risks associated with day to day living. Records evidenced staff followed the guidance to keep people safe.

Where risks were associated with behaviours that may challenge specialist input had been sought. For example, one person could present behaviours that may challenge and they had been assessed and were being monitored by the learning disabilities team. Triggers to behaviours were listed to help staff prevent these behaviours. Triggers included the person becoming tired, being hungry or thirsty and being 'overloaded with verbal information'. Warning signs the person was becoming anxious and distressed were also provided for staff. Care plans contained 'prevention strategies' for staff to help avoid the person becoming anxious or distressed. These included consistency, following established routines and ensuring the person had 'quiet time' in their 'own space'. Records confirmed staff applied and followed guidance and strategies, maintaining the person's safety.

Staff were effectively deployed to meet people's needs. The registered manager told us "Staffing is set by our clients support needs and this is constantly under review". Staff rotas evidenced planned staffing levels were consistently maintained. Where people received support in their own homes rotas confirmed staff were also

effectively deployed.

Staff told us there were sufficient staff to support people. One member of staff said "If a person is supposed to be supported by two people, then there are always two people. We never work short".

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the service. These included employment references and Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff were of good character and were suitable for their role. The registered manager told us staff were initially assessed to ensure they were caring. They said "We have turned down some very qualified staff candidates because we could not be sure they were caring". People's relatives were also invited onto interview panels to enable them to ask candidates questions.

People received their medicine as prescribed. Where people needed support we saw that medicine records were accurately maintained and up to date. Medicines were stored securely in people's homes. Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. We spoke with staff about medicines. Staff comments included; "I received medicine training during induction followed by three observations. I do yearly refresher training as well". Another member of staff told us, "I wash my hands first to prevent infection, check the MAR chart, support the person with medicines and then sign the MAR chart afterwards".

Good

Is the service effective?

Our findings

People's relatives told us staff knew people's needs and supported them appropriately. Comments included; "Staff know him really well", "Staff are quick to get to know her" and "They have involved the learning disability team who are going in weekly to try and help his interaction".

People were supported by staff who had specialist training to meet their specific needs. For example, one person had specific needs relating to their condition and we saw that only staff who had received the training to meet this need were consistently deployed to support this person. One member of staff requested specific training in autism. The service supported this staff member by funding them to undertake a master's degree in autism through the open university.

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction and completed training when they started working at the service. This training included safeguarding, moving and handling, epilepsy awareness, autism, medication and infection control. The induction was spread over a six month working period where staff completed training modules and worked using the knowledge they had acquired. Once senior staff felt this knowledge and skill base was embedded in their practice staff progressed to the next module. Staff performance was monitored throughout the induction process. The induction was linked to the 'Care Certificate', a nationally recognised qualification. We spoke with staff about the induction process. Staff comments included; "My induction was really good. It included e-learning and face to face training", "Induction helped me to understand working with people with learning disabilities" and "I shadowed and experienced member of staff for two weeks".

Staff told us, and records confirmed they had effective support. Staff received regular supervision. (one to one meeting with their line manager). Supervisions and appraisals were scheduled throughout the year. Staff were able to raise issues and make suggestions at supervision meetings. For example, we saw many examples of staff requesting further training and this training being provided. Staff were also supported through spot checks and observation of their care practice. These were regularly carried out by senior staff and the results were fed into staff supervisions. We spoke with staff about support within the service. Staff comments included; "We get supervisions every two to three months and discuss what's working and what is not", "I discuss my personal development training needs during supervisions" and "My manager asks me how I am doing and what I want to change".

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. 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 was knowledgeable about how to ensure the rights of people who lacked capacity were protected. Where people were thought to lack capacity mental capacity assessments were completed. One assessment we saw was carried out by the registered manager, senior clinical psychologist and a psychiatric

registrar. People and their families were involved in capacity assessments.

We spoke with staff about the MCA and received mixed responses. Staff comments included; "MCA is about giving choices during care", "I'm not sure what MCA is about. I only did e-learning" and "I think I need more training in MCA". However, it was clear from care records, daily notes and our conversations with staff that they applied the principles of the MCA in their daily work. We evidenced staff offered choices, ensured people could understand, gave people time to consider and respected their choices and decisions.

At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation. These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the supervisory body. The registered manager knew how to report any concerns and was aware the court of protection was the decision maker relating to DoLS. They told us they continually assess people in relation to people's rights and DoLS.

The service sought people's consent. Every care plan contained a 'choice and control' section that highlighted 'decisions I make myself'. Staff were provided with a detailed list of 'decisions' the person was able to make for themselves. For example, One person had stated 'I like to choose what I wear each day'. Another had stated 'I like to choose what I eat and drink at meal and snack times' and 'I can decide when I have a bath'. The care plans also highlighted decisions the person needed support with. For example, 'I need support to plan my daily activities' and 'I need help with decisions when I am anxious'. Where people could not make decisions staff were guided to fully support the person. For example, where people were unsafe or did not understand about road safety awareness. People had signed care plans, where they were able, consenting to care being provided. Where they could not sign we saw evidence the person and their family had been involved and signed to 'agree the service supported the person in their best interest'. One member of staff said, "I always ask for permission before I support any person".

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included people's GPs, psychologists, dentist's speech and language therapists (SALT), occupational therapists and the learning disabilities team. Details of referrals to healthcare professionals and any advice or guidance they provided was recorded in people's care plans.

People had enough to eat and drink. Care plans contained information about people's preferences and details of how people wanted to be supported. For example, one person could 'become fixated' on certain foods and drinks and needed support to choose alternative foods. Staff were guided to offer 'limited' choices so the person would not become confused. Staff were also advised to ensure there were 'plenty of suitable foods available'. This supported the person to make meaningful and healthy choices. Another person could eat independently and staff were guided to avoid 'too much sugary food' as this could affect the person's behaviour. Details of people's food and drink preferences were listed in the care plans and also provided in picture form to enable people to make their own choices.

Good

Is the service caring?

Our findings

Relatives told us people benefitted from caring relationships with the staff. Comments included; "Staff are absolutely lovely and the care is brilliant", "There is nothing wrong with the care. I think he is well looked after", "He is very happy there and is always happy to go back when he has been home to visit us" and "Staff are caring".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. During our inspection a person visited the office. The person was greeted warmly buy office staff and they were introduced to everyone. Staff engaged in conversation with the person using their preferred name and spoke to them respectfully. The person was excited about the Queen's birthday and spoke about the celebrations. Staff listened attentively and joined in with the person's enthusiasm. This promoted the person's dignity and endorsed their comments as interesting and valid ensuring the person did not feel patronised or belittled. Care plans gave guidance to staff to promote people's dignity. For example, one person could sometimes fail to close the door when having a bath or using the toilet. The plan stated 'prompt [person] to close the door when bathing or using the bathroom'.

We spoke with staff and asked how they promoted people's privacy and dignity. Staff comments included; "We close doors and give choices during personal care" and "I knock on doors before entering and I give them (people) space during personal care. I don't hurry them".

People's independence was promoted. Care plans contained a 'support my independence' section which gave staff guidance on how to support the person to remain independent. For example, one person's support plan stated 'Give one instruction at a time, use key words with minimal language and be patient and consistent'. This allowed the person to understand what needed to be done so they could then do 'what they can for themselves'. People had also provided a list of requests that would enable them to be independent. For example, one person had stated 'get me to do one thing at a time, let me do things at my own pace and don't rush me'. One relative said "They have made him really, really independent since he has been there. He can cook and clean, he couldn't do anything like that before he went there". One member of staff said "I allow the person to wash themselves as much as they can. It gives them a bit of independence".

People were involved in their care. We saw people and their relatives were involved in reviews of their care and relatives had signed reviews and changes to their support plans. Relatives we spoke with confirmed they we involved. Relative's comments included; "They always keep me up to date and we have a yearly review", "They always ring me if there are any changes", "Staff are normally really good" and "They keep us involved. We have a monthly written report which includes pictures showing us what he has done". One relative gave us a slightly different view point. They said "I don't have regular reviews but I talk to staff daily. I very often have to instigate meetings". We saw that regular reviews were scheduled for people, the frequency being dictated by the needs of the person. For example, one person had an annual review whilst another person had a review every two months. We could not find any evidence that supported this relatives comments.

The service ensured people's care plans and other personal information was kept confidential. When we entered the offices of MacIntyre Central England Support the registered manager greeted us and checked our identity before allowing us to proceed with the inspection. People's information was stored securely at the office and we were told copies of care plans were held in people's homes in a location of their choice. Where office staff moved away from their desks we saw computer screens were turned off to maintain information security. We spoke with staff about confidentiality. Staff comments included; "We do not discuss people outside work" and "I do not talk about personal information to other people".

People's care was recorded in daily notes maintained by staff. Daily notes recorded what support was provided and events noted during the day. These provided a descriptive picture of the day and gave staff information relating to the person's moods and wellbeing. For example, one person had complex needs and could present behaviours that may challenge. The daily notes gave a clear picture to the person's moods and enabled staff to respond to this person's care needs on a day by day basis.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to accessing the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person's care plan stated "I like to go out regularly and I like football, swimming and shopping'. Another person had stated 'I do not have any religious needs'. Staff we spoke with were aware of people's preference

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person had difficulty communicating verbally and used alternative method to communicate. The care plan noted how the person used pictures and picture cards to communicate and informed staff the person could become confused if too many words were used when speaking to them. Staff were guided on how to communicate with this person and to allow the person to 'express themselves'. Guidance stated the person would 'use pictures, point' or 'guide staff' to what they wanted. A list of pictures and symbols were provided along with a detailed 'communication profile' which included signs, symbols, key words and notes on body language to assist with communication. This person's support plan demonstrated both the person and staff had created the plan together and evidenced the plan was personalised. The person's sense of humour was evident as they had stated 'you must join me in my world' and 'don't panic'. One member of staff said "We support a lot of people with speech and language disability. We maintain eye contact, observe for body language and show them pictures".

People received personalised care. Care plans were personalised reflecting their needs and preferences. Detailed notes of support people needed were included and guided staff to enable them to support people in a personalised way. For example, one person had stated they were able to dress independently but 'needed support to put clothes on the right way round'. Another person had stated 'I am an active person but I need to be observed'. For one person a structured and consistent daily routine was essential to prevent them becoming anxious. We saw their care plan highlighted this need and a detailed daily routine was provided for staff to follow. This included breakfast times, time medicines were required and bath times. Records evidenced these routines were followed and the person supported in a personalised way.

Relatives knew how to raise concerns and were confident action would be taken. Everyone we spoke with knew how to raise a complaint and felt they were listened to. One relative said "I know how to complain. There is a form. I can complain to the manager". Information was available to people and their relatives on how to complain and we saw complaints were dealt with in a timely and compassionate way. All complaints were recorded and investigated and those we saw were resolved to the complainant's satisfaction. Outcomes from complaints were followed up by senior staff and managers and any lessons learnt and actions taken were recorded. For example, following investigation into one complaint the registered manager changed the procedure for booking staff training to reduce the occurrence, whereby staff were training at times of high need. This improved the service provided.

Compliments were also recorded and the registered manager told us "These are displayed, with their permission, in people's homes and rooms so that both our clients and staff can be aware of the positive feedback".

The service sought people's and their relative's opinions. Regular questionnaires were sent out to families giving them the opportunity to comment on the service provided and raise concerns or suggestions. The service analysed the results to improve the quality of service. For example, one survey identified some relatives were unsure of who they were speaking too when they rang people's homes and staff answered. Photographs with staff names were sent to people's families to help identify them and resolve the issue.

People were protected from the risk of social isolation. People's care plans contained a weekly planner of activities they wanted to engage in. We saw the activities reflected people's hobbies and interests. People engaged in their hobbies and interests and went on trips out. Care plans evidenced how activities helped people to develop skills and achieve their goals. For example, one person liked swimming and had set themselves a personal goal to swim a number of lengths of the pool. Their progress was recorded in the care plan and we saw they were steadily increasing the distance they could swim and would soon achieve their goal. We spoke with relatives about activities. Their comments included; "Staff are very active at doing things with her and keeping her engaged", "They took him on holiday, it was really lovely. He really enjoyed it" and "They take him to football, swimming and bowling".

Good

Is the service well-led?

Our findings

Relatives we spoke with told us they knew the registered manager. Comments included; "Manager is brilliant. Very responsive, she will always sort things out straight away", "She has made lots of changes. If anything is needed she will always try and get it for them (people)" and "There was an issue with another relative. The manager has been very responsive, trying to sort it out".

Staff told us they had confidence in the service and felt it was well managed. Staff comments included; "My manager is approachable and I can ask for support any time", "I have a very supportive manager. If I ask for help, I know I will get it" and "Manager is always on the other end of the phone".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced. One member of staff said "Some of our clients can be very challenging to care for but we resolve any issues by working as a team".

The registered manager spoke about their vision for the service. They said "I want to see us use continuous reflection on how we support people. I want to be sure their environment is suitable and that we review our practices constantly to provide the best care we can".

Accidents and incidents were recorded and investigated. The results of investigations were analysed by the registered manager to look for patterns and trends. For example, there was an incident where one person became anxious and pushed another person over. Neither person was injured. Triggers to this behaviour, which included noise and the staff member being late due to traffic were identified. An action plan was created to reduce the risk of reoccurrence. The registered manager implemented changes to the staff rota to reduce the risk of lateness and they purchased a pair of ear defenders to help the person cope with any noise. Social stories were also created to help the person understand why staff were occasionally late. We spoke with the registered manager about this. They said "[Person] has responded well to these measures and he loves his ear defenders which he carries with him all the time".

Staff told us that learning from accidents and incidents was shared through staff meetings and briefings. Staff meetings were held monthly and provided updates on people's care, current issues and an opportunity for staff to share learning, make suggestions and raise concerns. For example, a recent incident at a GP surgery was discussed and following staff input, measures were put in place to reduce the risk of reoccurrence. Staff spoke with us about communication. Comments included; "I receive handovers from colleagues and read the communication book for care updates" and "We use the communication book for handover and updates. Records confirmed regular staff meetings and handovers took place.

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and assess procedures and systems. Audits covered all aspects of care including risk assessments, care plans, training and medicine records. Audit results were analysed and resulted in identified actions to

improve the service. For example, one audit identified a need to improve a person's safety. The person's communication plan was reviewed which identified the person's preferred 'objects of reference' could sometime distress the person. These were pictures the person used to help them communicate. The person's care plan was then reviewed and changes made to the objects of reference. The review was completed in partnership with the 'Intensive support team' Oxfordshire, the learning disabilities team and specialist behaviour nurses. We saw the situation was being monitored by the registered manager.

The area manager compiled a quarterly report to look for patterns and trends across the service. This included audits, safeguarding, complaints, health and safety and accidents and incidents.

The service conducted annual staff surveys to obtain staff views. Senior staff also conducted interviews with staff to seek their opinions. The information was collated and analysed and the results feedback to staff. All the results we saw from staff were extremely positive.

There was a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.